State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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APPENDICES

1.4 OVERVIEW OF THE STATE

State History: New Mexico is a relatively young state achieving statehood as recent as 1912 and a state whose history reflects the imprints of many cultures and sovereigns. Human presence in the area dates back to the "Clovis Man" circa 9,500 B.C. During the first few centuries A.D, most of the area population settled into villages located along the Rio Grande River. It was these pueblos and nomadic tribes that the Spanish explorers encountered during their expeditions into what was then the northern frontier of New Spain in 1527. Despite many outside influences, the pueblos still reside in this area and have retained much of their culture such as distinctive styles of baskets and pottery crafts. Spanish rule of New Mexico began in 1598 and ended when Mexico gained its independence from Spain in 1821. A quarter century of Mexican rule ended in 1846 when the United States declared war on Mexico and three months later, General Kearney entered Santa Fe and took possession of the territory known as New Mexico. Sixty eight years later and after many attempts to move from a territory to state, New Mexico, Land of Enchantment, was granted statehood.

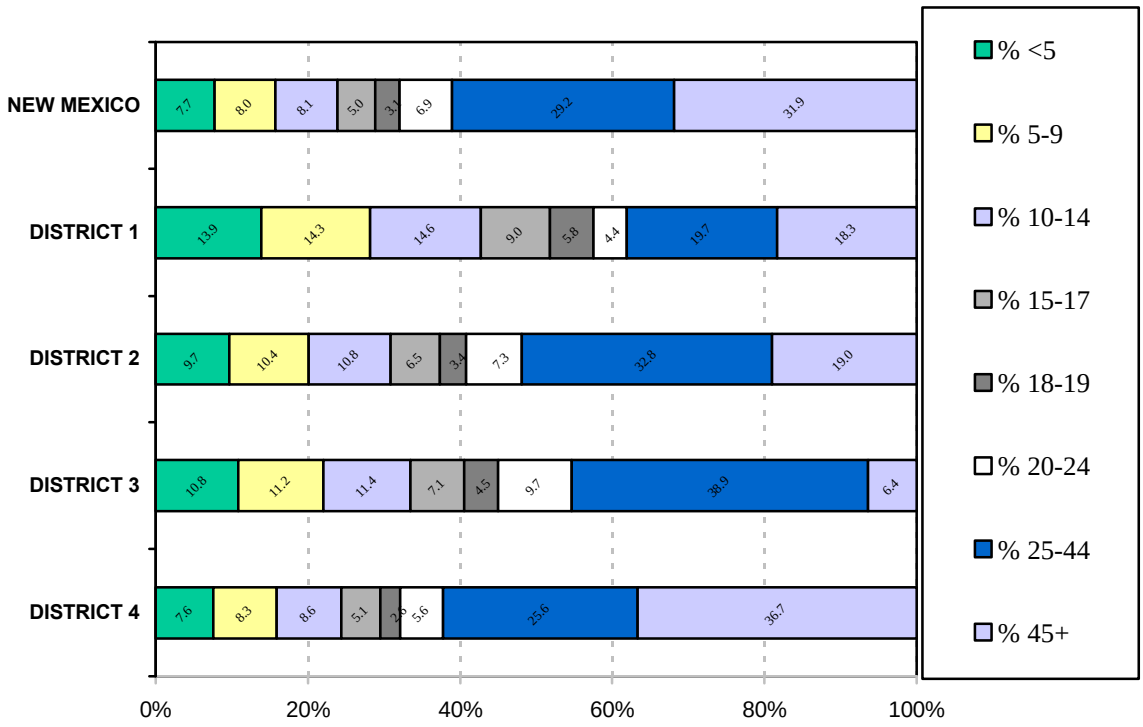
Many reasons have been offered about why it took New Mexico so long to achieve statehood: lack of knowledge about the territory and its people, some thought that the predominant Hispanic and Indian population were too 'foreign' to be admitted to the United States, even the state name has been blamed for the delay leading some to propose during the quest for statehood that Lincoln or Navajo would be a more suitable name. Finally, on January 6, 1912, New Mexico, Land of Enchantment was admitted as the 47th state.[1]

The state's history and cultural diversity are important backdrops to understand the challenges of delivering health care services in New Mexico. Factors such as the rural nature of the state, groups who speak other languages, limited number of health care providers, distances between health care facilities, as well as the high levels of uninsured or under-insured, poverty, literacy and isolation all impact health care delivery in New Mexico.

Population Demographics: New Mexico is one of the top ten fastest growing states in the nation. From 1990 -1997, New Mexico saw a 14.1% increase in population but despite this growth, the state has a population density of only 14.3 persons per square mile. New Mexico's county population densities range from a high of 451 persons per square mile in urban Bernalillo County to less than half a person per square mile in rural Catron and Harding counties. Much of the State's population is classified as rural and only seven New Mexico cities have populations over 30,000.[2]

With a total estimated population of 1,729,751 in 1997, New Mexico ranks 36th in population size yet first in proportion of Hispanic population and second for American Indian population. It is the only state in which no single major racial or ethnic group holds a majority for the population.[3]

Figure 1: New Mexico Population per Public Health District



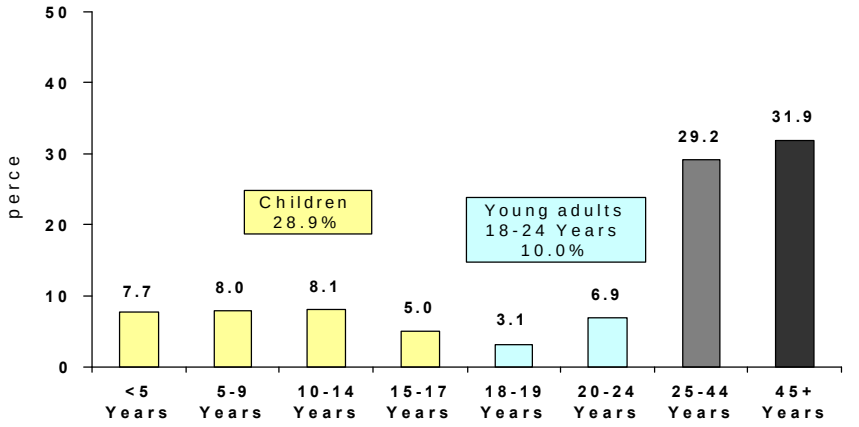
Because of a general decrease in birth rates, increased life span and varying rate of the in-migration, the age distribution of New Mexico's population has changed in the past decade. From 1990-1997, the proportion of the population in selected age groups was not markedly different from the US, however the percent change by age group in New Mexico was remarkably different from the United States in all but children age 5-17 years as seen in Table 1.

Table 1: Population Distribution and Change by Age Groups, New Mexico and United States

	Percent Population 1997		Percent Change 1990-1997	
Age Group	New Mexico	US	New Mexico	US
0-5 Years	8.1%	7.2%	9.0%	4.3%
5-17 Years	20.3%	18.8%	10.0%	11.3%
18-44 Years	40.4%	40.6%	9.8%	1.0%
45-64 Years	19.8%	20.7%	28.0	19.6%
65+ Years	11.3%	12.7%	20.7%	9.1%

Figure 2: Population by Age Group 1997:

New Mexico Population by Age Group: 1997
Source: U.S. Bureau of the Census Population Estimates



Population of Children

In 1997, the 499,322 children through the age of 17 in New Mexico represented 28.9 percent of the total population (1,729,751). Young adults ages 18 through 24 represented 10.0 percent (173,532) of the total population.

Population by Race and Ethnicity: As noted earlier, the origins of New Mexico's population are culturally diverse. In 1998, nearly half (47.96%) of children and youth age 0-24 were of Hispanic origin many of whom trace their heritage to the Spanish settlement of the state in the 1500's. Native American children and youth comprise 12.35% of the population; nearly 2/3 being Navajo and the remainder distributed across 19 Pueblos and 2 Apache tribes. Only 2.8% of the state's population is Black and 1.6% Asian. [4]

Per Capita Income: In 1997, New Mexico ranked 47th in per capita income (PCI); in 1998 the ranking dropped to 48th with a PCI of $19,936 compared to the national average of $26,412.

Unemployment: In 1998, 6.2% of the population was unemployed compared to 4.5% in the nation. In September 1999, the New Mexico unemployment rate of 6.1% was 3rd highest in the nation. County rates of unemployment vary from a low of 2% to a high of 17.8% in northern Mora County.[5]

Poverty: The proportion of people living in poverty in New Mexico remains high by comparison to other states and the nation. Most recent state and county estimates note the following age distribution for people living at or below the Federal Poverty Line (FPL) in New Mexico:

- ✓ 32% of children and youth under 18 years of age;
- ✓ 29.2% of school age children age 5-17;
- ✓ 38.9% of children under the age of 5 years.[6]

There is wide cross-county variation in the percent of the population living under the FPL:

- ✓ 20.2% of the total state population
- ✓ 29.4% in McKinley County (where the median household income was $20,951)
- ✓ 12.4% in Santa Fe County (median household income $36,948);
- ✓ 2.1% in Los Alamos County (median household income of $67,101). This outlier can be attributed solely to the presence of the Los Alamos National Laboratory which also allows this county to claim more PhDs per capita than any other county in the United States.

For children under the age of 18, the percent of the population living at or below the FPL also shows wide variation:

- ✓ Luna county with a population <18 of 3,378 has 49.1% living at or below the FPL,
- ✓ McKinley county at 48.10%;
- ✓ Santa Fe County at 20%,
- ✓ Los Alamos the lowest at 3%. [7]

Food Insecurity and Hunger, 1996-1998: On average, more than 90% of households in the United States were food secure and 9.7% were food insecure meaning that there was inadequate access to enough food to fully meet basic needs. New Mexico ranks 50th in the nation with 15.1% of all households noting food insecurity. While 3.5% of US households noted food insecurity reaching levels of severity great enough that one or more household members were hungry at least some of the time during the year due to inadequate resources for food, the New Mexico estimate was higher with 4.7% of households ranking the state 48th in the nation. [8]

Food insecurity is closely linked with poverty and this association is apparent when poverty rates are compared with state rates for food insecurity. At the national level, 13.6% of the US population lives in poverty and 9.7% of US households had food insecurity. For this same period, New Mexico ranked 50th in the nation for this combined measure and nearly 24% of the New Mexico population lived in poverty with 15.1% of households having food insecurity.

Food stamp use is expected to be associated with the prevalence of food insecurity. New Mexico's food stamp use (12.5%) was less than the reported food insecurity (15.1%). The report states that where food stamp use was lower than food insecurity prevalence, there is a need to investigate the extent to which these departures represent significant under-served populations, and to what extent they represent to problems with the food security measurement methods.[9]

Food Stamps: The Food Stamp Program served 168,238 recipients in April 2000, 9.7% of the total population. Recipient ratios vary by county, the lowest 9.7% Los Alamos and the highest McKinley at 22.2%.

Temporary Assistance for Needy Families (TANF): The TANF Program served 67,814 recipients in April 2000; this was 3.9% of the state population of 1,736,931. The proportion of the population on TANF varied by county: from 0.2 in Los Alamos to 8.2% in Socorro County. The distribution of TANF recipients by race and ethnicity is seen in the table below. As compared to the population, families of Hispanic, Native American, African American origin are over-represented.

Table 2: Demographic Profile of Recipients by Program, April 2000

	Food Stamps	TANF One-Parent	TANF Two Parent	General Assistance
Adults Age 18 and over	47.9%	34.9%	41.6%	92.0%
Children Under Age 18 Years	52.1%	65.1%	58.4%	8.0%
Male	41.3%	35.0%	47.2%	56.1%
Female	58.7%	65.0%	52.8%	43.9%

	Food Stamps	TANF One-Parent	TANF Two Parent	General Assistance
Hispanic	56.6	61.4	54.0	49.3
White	26.0	19.9	20.6	41.9
Native American	13.8	14.6	23.2	4.7
Black	3.1	3.9	1.6	4.1
Asian Pacific Islander	0.5	0.2	0.6	0.0

Of the recipients who are children, the following trends are noted:

- 52.1% are on Food Stamps
- 65.1% are in single TANF parent families
- 8.0% are on General Assistance
- 58.4% are in TANF two parent families

Low Income Uninsured Children: New Mexico consistently ranks among the last in the nation for children living in poverty and who are uninsured. In 1993-95, the state ranked 48th in the nation following Mississippi and Louisiana for percent of children at or below 200% of poverty; it was 50th in the nation for percent of children at or below 200% of poverty without health insurance. In 1994-95, the state tied with Mississippi for 50th place for children living below 200% FPL; and New Mexico and Texas tied for 50th place for percent children at less than 200% FPL without health insurance. In 1995-97, New Mexico was 50th ranked for percent children at less than 200% FPL and was 49th after Arizona for percent children at less than 200% FPL without health insurance.[10]

Table 3: Low Income Children and Low Income Children without Health Insurance in New Mexico

(Years and Population		At or Below 200% Poverty				At or Below 200% Poverty Without Health Insurance			
Years	Total Pop	No.	SE	%	SE%	No.	SE	%	SE%
1993-95	549,000	306,000	21.9	55.3	2.7	107,000	13.0	19.5	2.1
1994-96	598,000	358,000	24.5	59.6	2.6	109,000	13.6	18.4	2.1
1995-97	628,000	373,000	25.2	59.3	2.6	111,000	13.7	17.7	2.0

Poverty and Health: The health status of adults is directly related to poverty. In 1998, only 3.9% of adults reported themselves to be in poor health; yet this figure is three times higher at 12.9% for those at less than 100% of the FPL. Conversely, an estimated 45.6% of adults claimed to be in excellent health but of those less than 100% of the FPL, this estimate was only 26.7%.[11]

Accessibility of Needed Health Services by Geographic Area: In a 1999 New Mexico Health Policy Commission Household Survey, respondents in north central New Mexico noted the highest percentage of households unable to access primary care all or part of the time (19.1%), preventative services (16.7%), eye care (21.2%) or dental care (32%). Southwestern and south central New Mexico had the highest percentage of respondents (14.7%) unable to access an emergency room all or part of the time. Average travel time and average mileage to a primary care provider was 14.5 minutes/6.6 miles in urban Bernalillo county in contrast to 29.9minutes/25.2 miles in rural Sierra and Socorro County.[12]

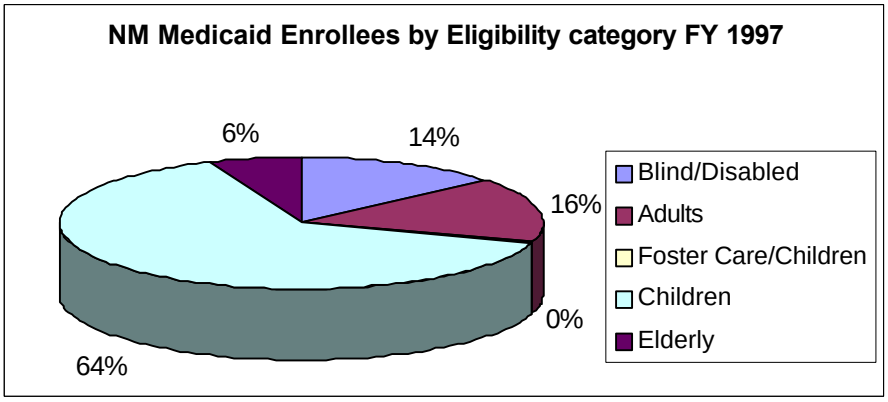
Trends in Health Insurance Coverage: 21% of New Mexico's population is uninsured compared to a national rate of 16.3%.[13] The percent of the total population of New Mexico receiving Medicaid and Medicare is 13.3% and 14.4% respectively with Medicaid decreasing 2.5% and Medicare increasing 2.2% since 1997. Children less than 18 years old in the state have an uninsured rate of 17.1% compared to 15.4% nationally. Non-elderly adults between the ages of 19-64 have an uninsured rate of 27.8% compared to a national rate of 19.6%; of this age group, 58.5% have employment-based insurance.

Table 4: Health Insurance Coverage in New Mexico 1995-1998[14]

Year	**1995**	**1996**	**1997**	**1998**
Uninsured % Population	25.6	22.3	22.6	21.1
Insured % Population	74.4	77.7	77.4	78.9
❑ **% Employer Insured**	44.3	49.3	51.8	56.3
❑ **% Private non employment**	7.0	6.8	7.5	5.2
❑ **% Medicaid**	19.6	19.7	15.8	13.3
❑ **% Medicare**	11.3	11.1	12.2	14.4
❑ **% Military**	5.3	5.7	3.5	3.9

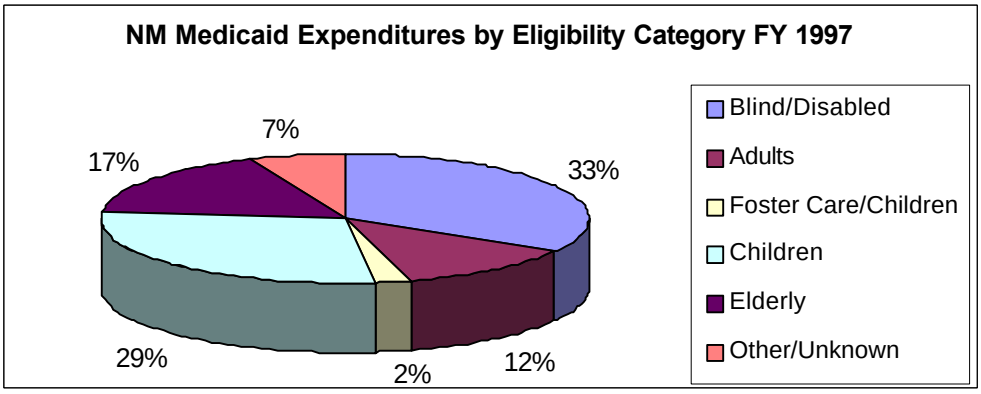
Medicaid in New Mexico: Medicaid is a major contributor of health care in New Mexico with 13.3% of population receiving coverage in 1998. Between 1998 and 1999, monthly enrollees increased an average of 7.8% and total Medicaid expenditures increased 3.8% during the same period. Children represent 63.8% of the total Medicaid enrollees.

Figure 3: Medicaid Enrollees 1997



Annual Medicaid expenditures have more than quadrupled since 1989 due to several factors including: expansion of coverage for pregnant women and children under the age of 19, a 25% increase in the state's population, and an increase in cost per enrollee.[15]

Figure 4: Medicaid Expenditures 1997



Maternal and Child Health: The state ranks **last** in the nation for the percent of women receiving the recommended level of prenatal care. In 1997, only 52.7% of all women in New Mexico received such care and at least 11.1% or 1 in every 9 births received no prenatal care. In McKinley County, in the western part of the state, only 30% of women received high levels of prenatal care.[16] The state also ranks among the highest in the nation for teen pregnancy rates with birth rates averaging 39% higher than the national

average. Nationally, 12.9% of all births in 1996 were to teen mothers compared to 17.8% in New Mexico.[17]

Another indicator, the Healthy Birth Index, which comprises all births with a birthweight >5.5 pounds, Apgar of 9-10, gestation of >37 weeks and mothers who had first trimester prenatal care, also reflects poor maternal and child health in New Mexico. Albuquerque ranked 26th of 36 cities ranked in the nation at 57.7. The top city average was 61.6 with a range was 70.2 for Charlotte, NC and 50.0 for the District of Columbia. The urban index for Albuquerque was only slightly better than the state index. New Mexico ranked 48th in the nation at 55.5. The National Index average was 66.8 with a range from 74 in New Hampshire to 50 in District of Columbia. California and Texas were not indexed.[18]

Educational Status and Literacy: Education and literacy outreach is a challenge in New Mexico. An estimated 21-23% of US youth and adults function at the lowest Level 1 literacy rate; in New Mexico this proportion is 20% (See full data in the Appendix). The county specific proportions for Level 1 literacy range from 5% in Los Alamos to 35% in Luna County. Although many Level 1 adults can perform many tasks involving simple texts and documents, all adults at Level 1 displayed difficulty using certain reading, writing and computational skills considered necessary for functioning in everyday life.[19]

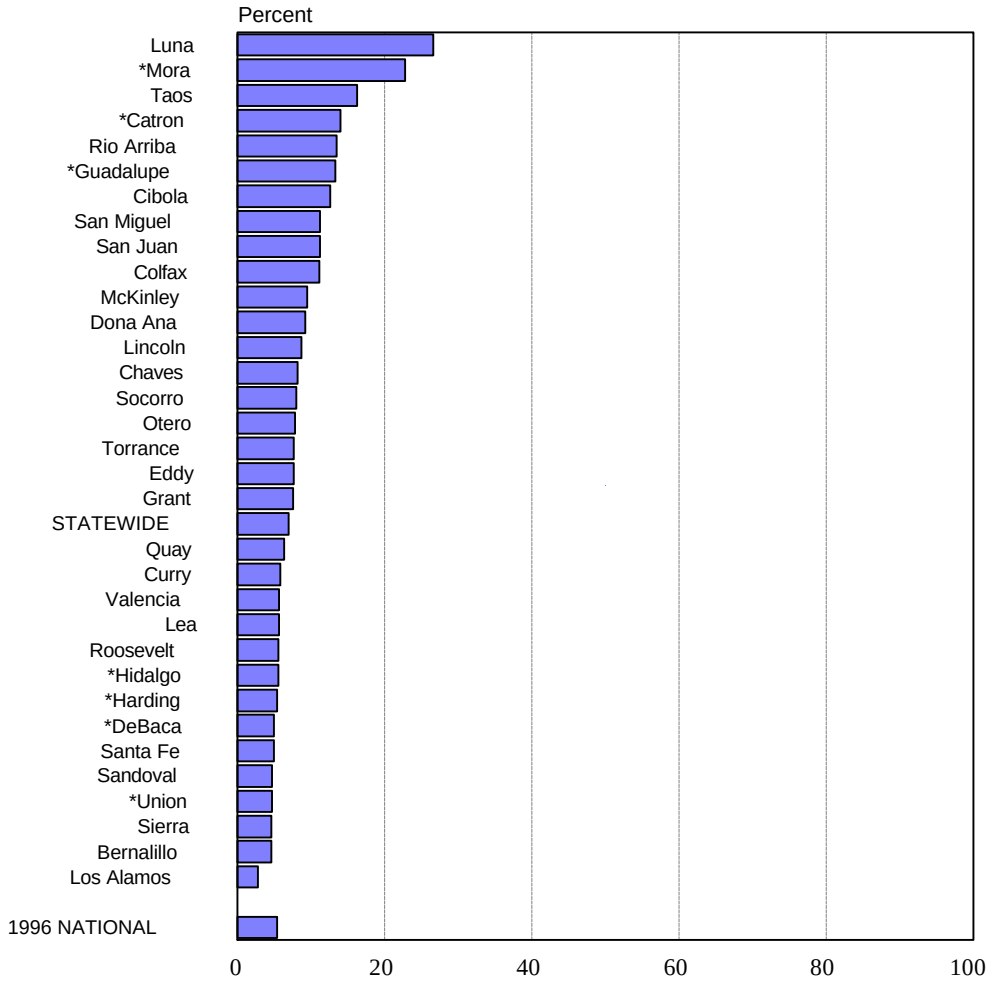
Nationwide Ranking Systems: Overall, New Mexico is paradoxical when one considers health indicators used in creating indices and ranking states. In spite of the fact that the state ranks 40-50th for access or SES measures, the state is among the top 10 for long term outcomes such as heart disease, cancer cases and total mortality. New Mexico is among the 10 worst states for violent crime, high school graduation, unemployment, adequacy of prenatal care (modified Kessner), first trimester prenatal care, lack of health insurance, support for public health care and infectious disease.[20] Overall poverty rates, in particular childhood poverty rates, show a strong negative correlation with health care quality. States with high poverty levels tend to rank significantly lower in overall health care quality that shows the profound influence economic conditions have on health. It will be very difficult for states to improve health care quality without improving the economic conditions. Childhood health deficiencies exacerbated by poverty are likely to impact overall health care quality for a state well into the future if not caught and corrected early.[21]

New Mexico ranked 44th in the Quality FIRST Index with health care costs of $223/ per capita; the state ranks in the bottom 5 states for childhood poverty. Strengths in New Mexico include the state's mortality ranking as better than the national average due to low lung cancer and heart disease deaths. Weaknesses include economic issues such as unemployment, lack of health insurance, overall poverty, childhood poverty, births to teens, suicide rate, dentist shortages, low prenatal care levels, incidence of immunizable diseases and days lost to illness. The New Mexico health care system is characterized by having a low usage of procedures, high penetration of managed care and health maintenance organizations in urban areas, low hospitalization days, and a low ratio of specialists to primary care physicians.

County comparisons of economic and health indicators are highlighted in the following graphs. An index of MCH Vulnerability is in development, based on this needs assessment. See DRAFT in the Appendix.

New Mexico Rates of Unemployment by County [22]

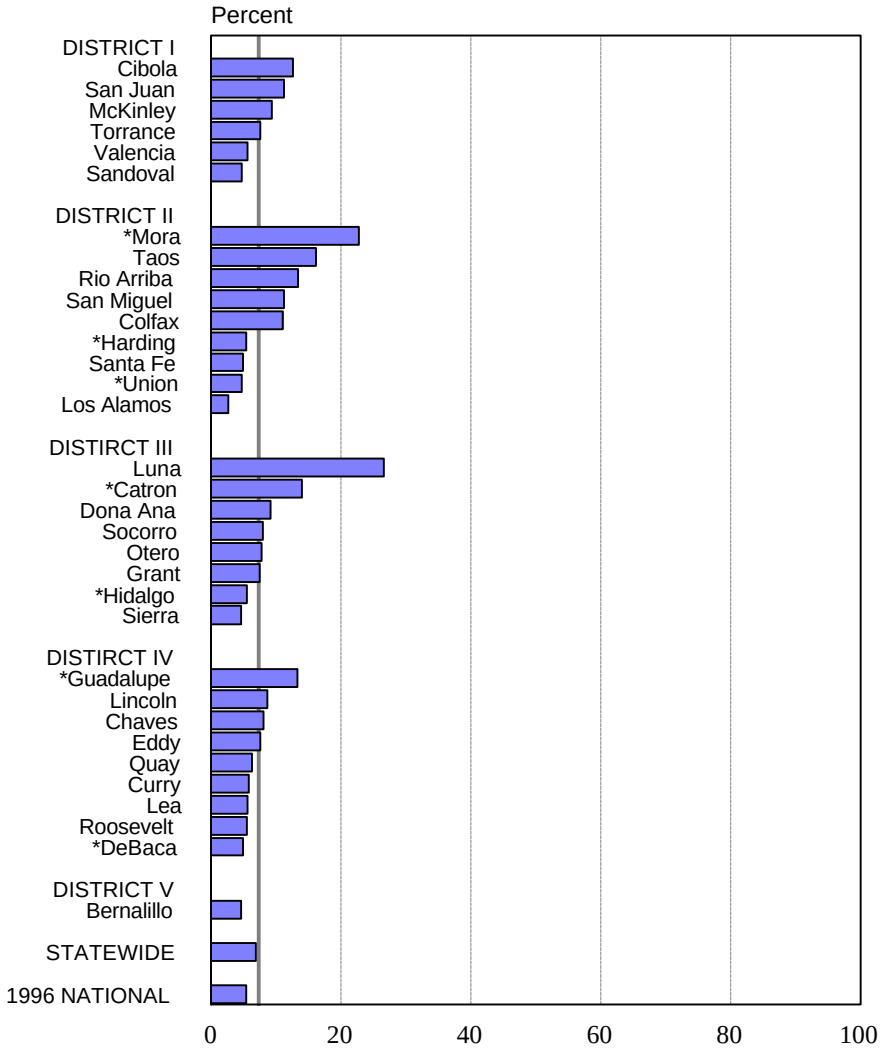
Figure 17. Rates of Unemployment by County
1995 -1997 Average



*Counties with population <10,000
Source: Economic Research and Analysis Bureau, NM Dept. of Labor

New Mexico Rates of Unemployment by Health Planning District [23]

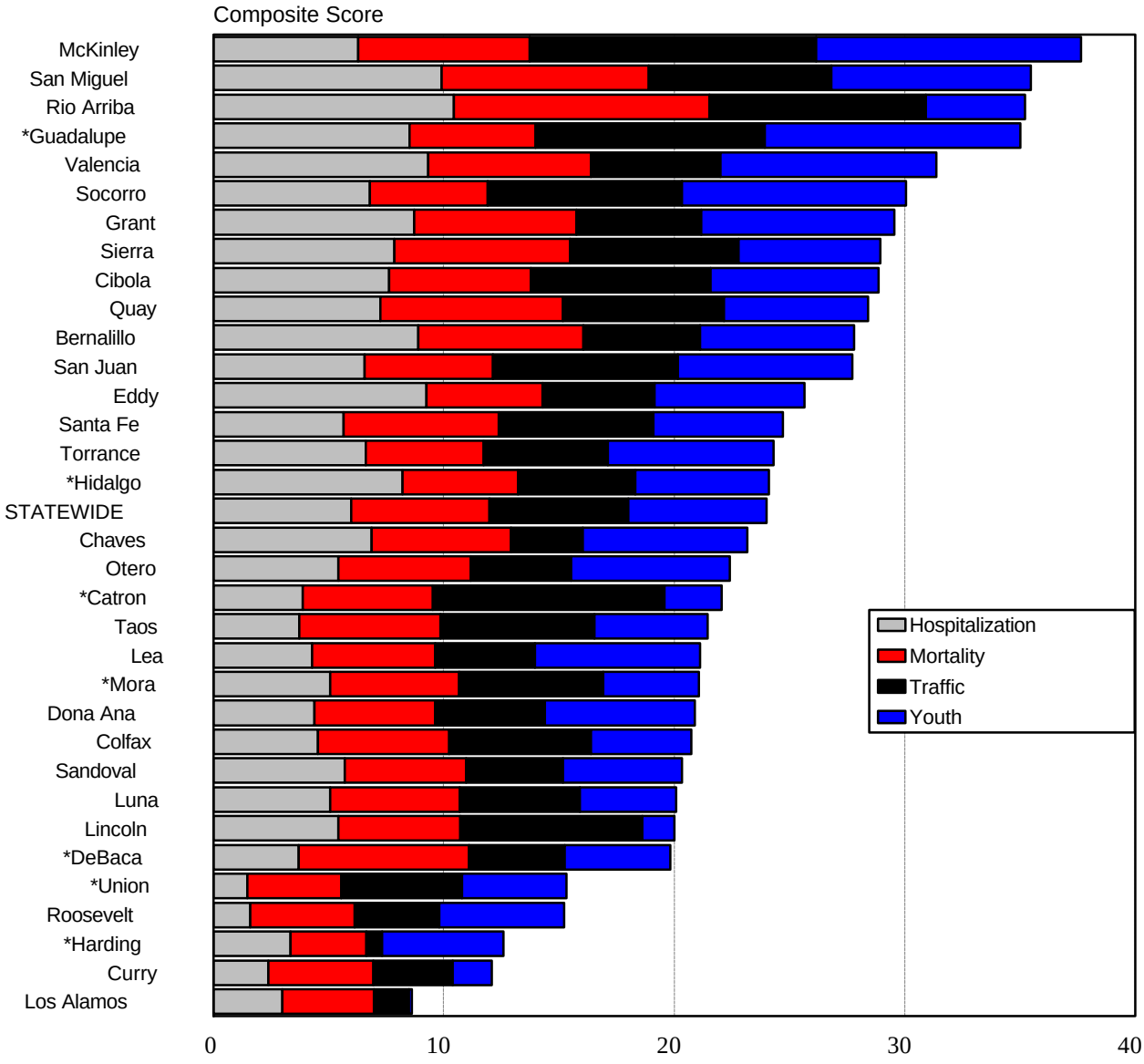
Figure 18. Rates of Unemployment by County and Health Planning District, 1995 -1997 Average



*Counties with population <10,000
Source: Economic Research and Analysis Bureau, NM Dept. of Labor

Composite Scores in New Mexico [24]

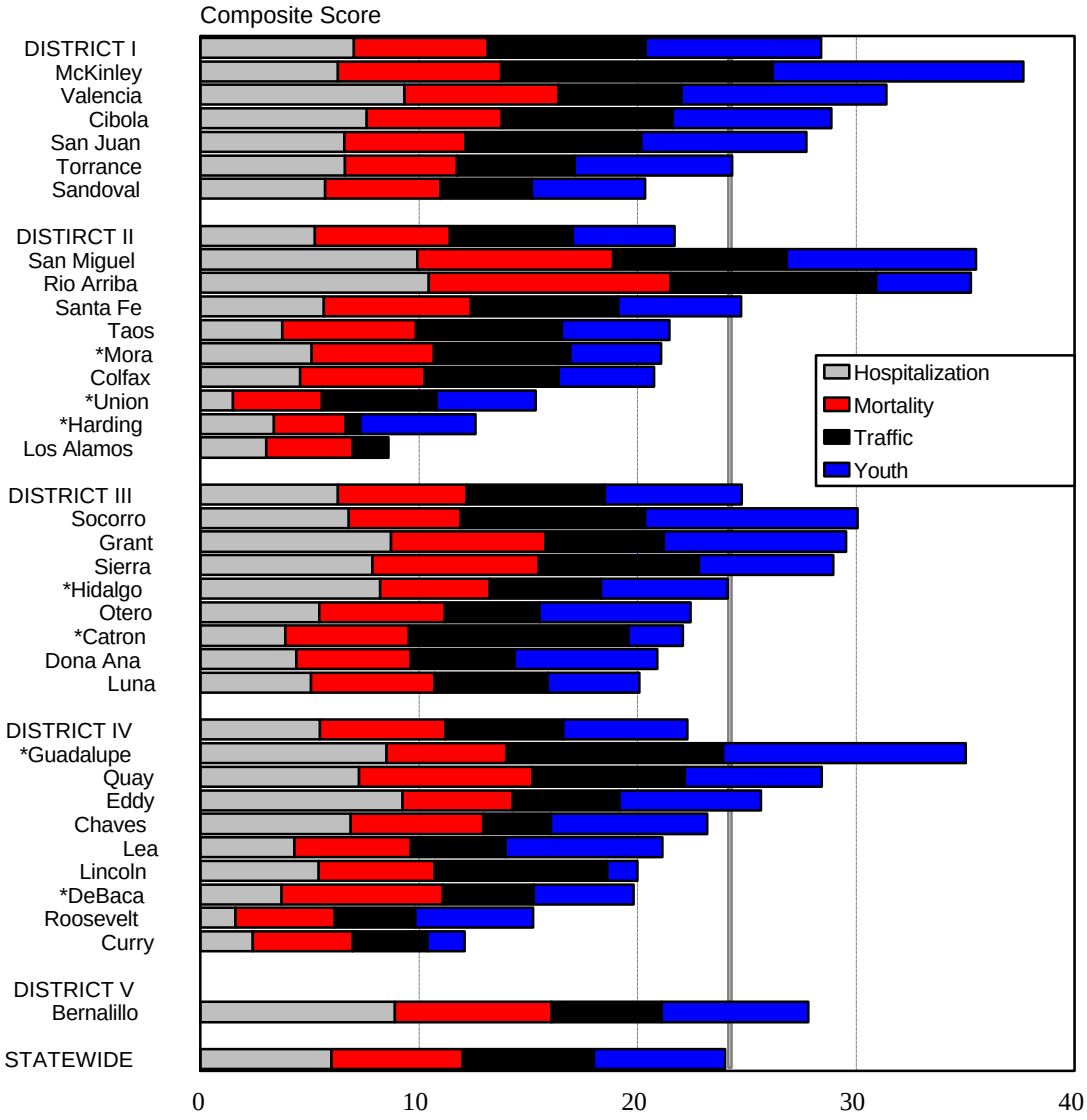
Figure 41. Composite Scores of Direct Indicators by County**



*Counties with population <10,000
**A constant was added to composite scores in order to convert negative to positive values.
Source: Office of Epidemiology, New Mexico Department of Health

Composite Scores in New Mexico [25]

Figure 42. Composite Scores of Direct Indicators by County** and Health Planning Districts



*Counties with population <10,000
**A constant was added to composite scores in order to convert negative to positive values.
Source: Office of Epidemiology, New Mexico Department of Health

State Efforts and Program Overview: The state has made a commitment to increase enrollment of eligible children for Medicaid services. New Mexico took the option of expanding eligibility for Medicaid from 185% to 235% of poverty rather than developing a separate program under the Title XXI State Children Health Insurance Program (SCHIP). SCHIPS Phase I began implementation in March 1999 and will eventually reach an estimated 5,500 children. MCH Title V staff from the Family Health Bureau have contributed to all phases of this new program. Two noteworthy accomplishments in the past year continue to be resources for maternal and child health: the County Maternal and Child Health Councils continue to strengthen their capacity for community health improvement, and the collaborative partnerships formed during the work on SCHIP Phase II.

The Balanced Budget Act of 1997 gave the states the option to establish a presumptive eligibility procedure to facilitate the enrollment of children in Medicaid. As part of this effort, the New Mexico Human Services Department (HSD) implemented the Medicaid On-Site Application Assistance (MOSAA) program on July 1, 1998. Application forms were shortened from 13 pages to 3 pages and over 2000 new sites where presumptive eligibility for children can occur is projected. Local health offices of the Department of Health carry a very large part of the burden for this new program. Programs such as Families FIRST, Children's Medical Services, WIC and other Public Health Division employees in the local health offices have been trained to provide Presumptive Eligibility and MOSAA, and have educated themselves in the Medicaid Managed Care (Salud!) enrollment process. Enrollment sites include schools, Head Start, primary care clinics, and child care centers. A 12-month continuous Medicaid eligibility guaranteeing coverage for an enrolled child independent of changes in family income became effective on July 1, 1998. The Human Services Department (HSD) hoped to reach 43,000 potentially eligible children not currently enrolled in Medicaid. An intense marketing effort of SCHIP Phase 1, "New MexiKids" targeted uninsured children started in October 1998. Outreach efforts have included radio ads in English, Spanish, and Navajo advertising the New MexiKids program.[26]

The Family Health Bureau (FHB) which houses the Title V MCH, Family Planning and WIC Programs features new and on-going initiatives in direct, enabling, population based and infrastructure building services. In family planning, efforts are directed at unplanned and untimely pregnancies which comprise an estimated 50% of live births, sexually transmitted infections and other reproductive health risks in the New Mexico population with a particular emphasis on teen pregnancy and male involvement in its prevention efforts. Family planning services-- both clinical and educational-- throughout the state are provided by the local public health offices and by providers who have contracts or signed agreements with the state.

All family planning activities are collaborative between federal, regional, state, local, profit, and non-profit organizations/agencies. Special focus projects include the Family Planning 1115 Medicaid Waiver; male involvement; the identification, assessment and referral for: violence, both domestic and sexual, alcohol, substance abuse, tobacco use (V.A.S.T.); sexual coercion; sterilization; quality assurance; adolescents; clinic management; and data management/fee collection.

Effective July 1998, the Family Planning 1115 Medicaid Waiver extended services for two years uninterrupted to all women at 185% of poverty. The Family Planning 1115 Medicaid Waiver is a fee-based service, thus allowing basic monitoring of program outcomes despite the rapid implementation of SALUD! To date, this program has seen much success as over 16,375 women have enrolled in this new service. Better communication is needed with the New Mexico Human Services Department (HSD) Medical Assistance Division (MAD) to ensure success of this initiative.

The Adolescent/Youth Development Program concentrates on primary prevention related to assets building and increasing protective factors that will reduce high-risk behavior.

The Dental Health Program has begun planning for a broader approach to MCH oral health than through sealants and fluoridation.

The consequences of Medicaid managed care on dental care has not been completely evaluated. In October 1999, the HSD increased the Medicaid reimbursement rates for oral healthcare providers. Preliminary results indicate an increase of approximately 6 percent in the number of participating general dentists.

The Office of Epidemiology, where chronic and infectious diseases are monitored, has indicated an interest in assessment of the 0-3 year old population with respect to primary prevention. The Family Health Bureau programs have responsibility for client services, systems development and monitoring with respect to the majority of these indicators.

The WIC program serves an estimated 10,000 mothers a year and 44,000 infants and children. In addition to WIC nutrition education and food assistance, the program refers mothers for health and social problems. The WIC program utilizes an electronic client system that features electronic benefit transfer [EBT] which is in essence “a smart card” that carries financial information. The NM EBT card was designed to allow for other health and immunization data to be added.

Processes to determine the importance and magnitude of problems included the Title V health status assessment, updates of the previous assessments, and specific surveillance initiatives of NM PRAMS, NM BDPASS, NM MMR, NM CFR, analysis of linked birth infant death files for 1987-1998, and the 1996 report for Linked Medicaid-Live Birth analysis to monitor maternal and infant health. Indicators were established using the Healthy People 2000 and 2010 document and collaborative assessment and planning between the state and local health offices.

The advantage of the Title V Block Grant funds is its flexibility for use in maintaining a safety net for some prevention and primary care services for populations that would otherwise not receive services. The funds also allows families to access existing services which may be categorical in nature, programs to assess the maternal and child population, population based screening efforts to be implemented, and to work toward developing a comprehensive service delivery system that meets the diverse needs of all individuals.

Medicaid continues to be seen as an alternative to the lack of universal health care in New Mexico. The Medicaid Managed Care Organizations (MCOs) are struggling to see the value in prevention

programs initiated by the Public Health Division. Title V funding is a valuable supplement to the direct and limited preventative services provided to eligible populations by the Medicaid program particularly in a state which also has much work to be done to combat the effects of poverty. Unfortunately due to a legislative decision to target the PHD for cuts in staff, contracts and travel, the full Title V MCH allocation could not be utilized.

The Public Health Division (including Title V staff) currently works with others in the Department of Health to provide input into the request for proposal process (RFP) for the Medicaid managed care contracts being awarded next year. The Department of Health funded a $3 million dollar substance abuse prevention initiative this year from existing budget. This initiative is intended to fund communities that wish to implement evidence-based interventions.[27] The Public Health Division contributed one million dollars in state general funds.

In the Spring of 2000 the Department of Health undertook a strategic planning process that embraces all Divisions of the Department. The Strategic Plan has two parts: 1) a description of the mission of the Department, philosophy and guidelines for public health practice and quality improvement; and 2) detailed statements of goals, objectives, performance measures and health indicators. A copy of the most current edition of the latter is found in the Appendix. Objectives that are worked on by the Title V MCH program efforts are found throughout the document. It is expected that with strategic planning the Department will be in a better position to adequately utilize performance based budgeting which is required by the NM State Legislature.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Title V MCH programs are located within the Family Health Bureau of the Public Health Division (PHD), in the New Mexico Department of Health (DOH). The Secretary of the DOH, J. Alex Valdez is a Cabinet Officer and reports directly to the Governor. There are two deputy secretaries, Jack Callahan for programs and George Parascandola for administration. Barak Wolff was named Public Health Division Director in January 2000; Marilyn Sakara was named Family Health Bureau Chief in April 1999 after serving in an acting capacity. The Maternal and Child Health Unit is proving to be a successful combination to maximize resources and coordinate activities to improve the health of women and children. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are found in Appendix.

Legislative mandated budget cuts have had a profound negative impact on filling vacancies and the ability to implement new initiatives and maintain current efforts. The Title V Director covered both the Title V Director position and the Title V CSHCN Director from July 1998 to November 1999 at which time the current CSHCN Director (Lynn Christiansen) was hired. The Bureau administrative staff consists of a part time Medical Director, an Administrator, a Systems Analyst, and a Clerk Specialist position that will be filled in Summer of 2000.

Due to a legislative decision to cut staff positions within the PHD Public Health Division, CMS lost two positions in FY 00, a Public Health Nutritionist 4 and a Clerk Specialist. With continuing PHD financial difficulties, CMS is experiencing an additional freezing of 2 state office positions, the Management Analyst and the Staff Development Specialist. A Clerk Specialist position that was previously housed within the CMS State Office will be transferred to the Family Health Bureau to assist in support services for the entire Bureau.

Regulations and Statutes: Specific bills in this past legislative session that will impact operations at the Department of Health during the next fiscal year included:

Healthier Kids Fund (HKF) expansion of approximately $1,000,000 bill was introduced this past legislative session. This would have allowed HKF to reopen its enrollment process as at this time, no new enrollments are possible. Another bill would have provided for the mandating of Newborn Hearing Screening and an increase in funding for the Hear Early program. Neither of these bills was passed.

Dental Issues: This was a year to integrate the legislation passed in 1999 regarding dental issues. The three major legislative initiatives were: the establishment of reciprocity for licensed dentists from other states which granted licensure to practice in New Mexico without additional examination; establishing collaborative practice for dental hygienists to practice semi-independently of dentists; and increasing the dental fees for the Medicaid program. New Mexico does not have a dental school so the state relies on dentists trained elsewhere to relocate. Reciprocity enhances this relocation immeasurably. With an adequate supply, more dentists will locate in the more rural parts of the state thereby increasing access. Collaborative practice for hygienists will increase access to the services preventive services required by the population including in the more rural parts of the state. The major barrier to dentist participation in Medicaid are low fees. With the increase in dental fees the number of participating dentists is increasing. Specific data showing the impact of the increase in fees is limited at this time.

Birth Defects Reporting: Birth defects that are identified from birth through age 5 were added to the list of Reportable Conditions, Office of Epidemiology, NM Department of Health. The reports are made directly to the Children's Chronic Conditions Registry in the CMS program.

1.5.1.2 Program Capacity

The New Mexico Title V programs continue to be in transition moving towards a balance of direct and enabling services along with population-based and infrastructure building initiatives. The mix is created by developments in the delivery of prenatal care and child health services, rapidly changing health care policies and financing, efforts based on community needs assessments and the response of the Title V program to federal, state and community initiatives affecting the MCH population. The majority of all MCH services and programs consist of state and community level partnerships that include the Title V MCH program as the lead partner or as a team partner. Key partners in providing services to the MCH population includes:

- NM WIC program within the Family Health Bureau,

- MCH Systems Development Program within the Family Health Bureau,
- Title X, Family Planning Program within the Family Health Bureau,
- School Health Program and Primary Care Programs in the Community Health Systems Bureau,
- Immunization programs in the Infectious Disease Bureau,
- Childhood Injury Prevention Program in the EMS/Injury Prevention Bureau, programs
- 45 Local Health Offices within Districts I, II, III and IV,
- US-Mexico Border Health Office in District III.
- Parents Reaching Out (PRO)
- Family Voices
- Healthy Start Initiative (2)
- LEND, University Affiliated Programs through the University of New Mexico
- Healthy Tomorrows Partnerships
- Other MCH grantees

Children Medical Services (CMS): The Healthier Kids Fund (HKF), administered by CMS since 1995, provides primary care coverage for all children ages 3-19 years with no other payment source. Due to limited funding new enrollment was curtailed in January 1999; income eligibility guidelines of 300% of poverty has been implemented effective July 1999 and the program is presently operating on 50% of its budget. There was a considerable decrease in the size of the HKF program as SCHIP was implemented, however there are still many children who are not eligible for New MexiKids and who would be eligible for HKF if that program was accepting new enrollments. With a cut of approximately 55% in the number of HKF children, social workers' caseloads have become more manageable. The more reasonable caseloads have made it possible for social workers to focus on comprehensive case management for children with special health care needs (CSHCN).

The CMS program has played a key role in sharing purchasing specifications and consultation about CSHCN with the SALUD! committees as Medicaid Salud! begins a 4 year Request for Proposal process. The SALUD! MCOs are reimbursing the CMS Program for specialty clinic services for their enrollees. Some MCOs are also reimbursing CMS for a maximum of two hours of case management associated with clients.

CMS continues to participate in the Double Rainbow Project in Sandoval County, which was funded by MCHB to develop a responsive system of health care with Medicaid Managed Care Organizations for children eligible for IDEA, Part C. CMS, along with the early intervention programs, is a Part C case management provider in several counties. The Double Rainbow Project recently completed the 1999 New Mexico Family Survey for children with special health care needs which addressed the families of children birth to four years, their use of the Family Infant Toddler Program services, accessibility to services, and suggestions for improvement.

CMS participates in the SSI Coalition to ensure that children who are receiving SSI benefits and those who have been denied services have sufficient resources to navigate the system.

The newborn genetic screening and prevention section was transferred to CMS two years ago. Work continues to integrate the program with traditional CMS activities and to consider ways to strengthen this role. A legislative memorial was passed to study the status of newborn hearing screening in the state. CMS, together with the Governor's Commission on the Deaf and Hard of Hearing prepared a report and presented it to the Health and Human Services Interim Legislative Committee. A recommendation was made to mandate Newborn Hearing Screening.

Of particular concern at this time is the dearth of services to address the chronic orthopedic and rehabilitation needs of children in New Mexico. Until recently, these services were provided for children with insurance, Medicaid, or no payor source through Carrie Tingley Hospital (CTH). The merger of CTH with the University of New Mexico Medical Center resulted in a change in the coverage of these services. Very few children without a payor source are able to receive services and CMS is unable to expand its program to include these medical conditions and meet this need due to its limited resources.

The Adolescent/Youth Development Program is designed to provide surveillance of the 10-24 year old population in NM. The mission of the program is provide resources, data, funding, and technical assistance on Best Practices in Adolescent Health to other State Agencies and local community groups working with that target population. The staff identifies strengths, weaknesses and gaps in promoting community based, family centered, culturally appropriate systems of service and advocates for appropriate programs and services to support this population. It is the goal of the program that all adolescents have the opportunity to reach their fullest potential with positive intergenerational partnerships as a basic infrastructure of life.

The Adolescent Pregnancy Prevention Coordinator position is currently vacant. However, the individual who previously held the position worked with several partners including the New Mexico Teen Pregnancy Coalition, State Department of Education, and the Abstinence Only Education Coordinator on a mapping project, Challenge 2005: Reducing Teen Pregnancy in New Mexico. This document is found in the Appendix and provides statistics on teen pregnancy by county, highlights the top ten counties with the highest rates, and indicates the teen pregnancy prevention projects in the state. A conference was held to share the data and begin planning efforts to impact change.

The IHS Albuquerque Area and Navajo areas, tribal health entities such as the Health Services Division of the Navajo Nation and the WIC program of the Navajo Nation, and tribal WIC programs, provide MCH Services for Native Americans. Tribal and BIA social services attend to needs of children. In the next year's MCH assessment update, a summary of Indian Health Services and tribal health information will be featured.

The Human Services Department administers the Medicaid Program. The Children, Youth and Families Department administers many programs including Head Start and other child care services, the family preservation and support initiatives, prevention and intervention units for child protective services and juvenile justice programs.

Family Planning Program emphasis continues to be on:
1) Direct medical services including physical exams; breast, cervical and testicular cancer screening; hypertension screening; anemia screening; sexually transmitted disease (STD) testing and treatment; pregnancy testing; and offering contraceptive methods;
2) Health education and counseling services including reproductive health, abstinence, contraceptive methods, STD and HIV risk reduction; and infertility counseling;
3) Community services including data collection and monitoring for trend; identifying strengths and gaps in services; participating in community committees and councils; and educating communities on a broad range of topics related to reproductive health.

National data indicate that family planning is very cost effective. To serve a woman at risk of unintended pregnancy at a family planning clinic costs approximately $150 a year compared to an average managed care cost of $3754 for labor and delivery. Cost benefit analysis indicates that for every dollar spent on family planning, $4 - $27 is saved depending on the population model used. Family Planning services are available to everyone regardless of age, sex, marital status, handicap, religion, income, race, ethnicity or national origin. Payment for services is on a sliding fee scale according to family size and income and is covered by the July 1998 the Family planning 1115 Medicaid Waiver. The issues of a lack of presumptive eligibility, incentives to refer women to the Waiver program, and difficulties coordinating with Human Services Department are seen as barriers to an even greater success of the 1115 Waiver Program.

Families FIRST (FF) is a perinatal case management program that provides services to Medicaid eligible pregnant women and children 0-3. The purpose of perinatal case management services is to assist appropriate individuals in gaining access to needed medical, social, educational and other services. Case management services may include coordination with providers of non-medical services such as nutrition programs or education agencies, when these services have been identified as necessary to foster positive pregnancy outcomes and promote healthier infants and children.

As of July 1998, the Families FIRST Program has successfully negotiated contracts with the three Medicaid Managed Care Organizations (Cimarron, Lovelace and Presbyterian). Because of the strong belief in the effectiveness of the Families FIRST model a collaborative partnership was developed. These partnerships were needed to produce an effective use of statewide resources and prevent a duplication of services.

Currently FF has a provider network with 59 sites statewide. These sites cover 32 out of the 33 counties in the state. They consist of 22 Local Public Health Offices and 37 Private Contractors. Between July 1, 1998 and June 30, 1999 there were 3133 pregnant women and 3591children receiving perinatal case management services. The proportion of private community providers to public health nurses is decreasing based on the low payment for services by the MCO's. Efforts to increase the payment are being made.

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Preventive and Primary Care Services for Pregnant Women, Mothers and Infants: The Bureau's marketing initiatives this past year included:

- development of a newborn genetic screening video, brochure, and poster
- the follow-up to "Day One" with "Day Two" booklets about toddlers' behavior and possible associated parental feelings
- billboards with public health messages
- Family planning media campaign;
- 50% of the media funded by HSD Medical Assistance Division.

Victor LaCerva MD, Medical Director of the Family Health Bureau, compiled the report *The Status of Children's Mental Health in New Mexico* to further support data-driven policy and programming and to be used as a grant writing resource by communities.

The Dental Program continues the statewide dental sealant program. The inability to recruit and retain dental hygienists has led to a strategy of using dental assistants as sealant operators. A hygienist is required to supervise the operators. Considerable time was spent on developing the recommendations for Senate Joint Memorial 21 that addressed recruitment, retention and geographic dispersion of oral healthcare providers and assuring access to dental services. This was followed by collaboration between HRSA, HCFA, the Dallas Regional Office and the DOH in hosting a dental summit where manpower and access issues were further discussed. The summit has led to the establishment of an oral health council, composed of interested individuals from throughout the state who are interested in oral health issues. This group is developing a strategic plan for oral health to be presented to the legislative members prior to the 60-day legislative session in 2001.

The Dental program provided oral health screenings for the Early Start/Head Start population in Santa Fe, Torrance, and San Juan Counties. The plan is to collaborate with WIC, Head Start and all early childhood programs serving low-income children to implement screening and on-site treatment for early childhood caries. Access to care by the Medicaid population continues to be a major issue in New Mexico. The DOH Dental Director and the Medicaid Dental Director attended a HRSA/HCFA sponsored national conference to develop partnerships to address the Medicaid access problem. This has led to activity in New Mexico to establish partnerships and to address access issues.

The Maternal and Child Health Unit includes:

- ✓ Maternal Health which oversees the practice of midwifery and access to perinatal care statewide;
- ✓ Child Health which works to improve the health of children birth-10, and
- ✓ County Maternal and Child Health which implements the County MCH Plan Act to develop comprehensive maternal and child health services to improve the health of childbearing women and their families.
- ✓ Statewide Systems Development Initiative integrates these efforts to improve maternal and child health with a focus on obtaining information regarding disparities in health status, access to services, and utilization of preventive health care. This mix of activities has enhanced resources for programmatic support and technical assistance to communities.

Maternal Health continues to oversee direct prenatal care services in ten to thirteen local public health offices, while expanding partnerships with private providers through provider agreements to ensure availability of prenatal care to medically indigent women where possible. For high-risk indigent prenatal clients, the program administers a fund for qualified private providers who give them care, on a fee-for -service- basis. The Maternal Health program regulates and licenses the practice of licensed midwives and certified nurse midwives (CNMs). This oversight ensures a pool of high quality providers of pregnancy-related care providers. In 1998, 22% of births in New Mexico were attended by CNM's. Thirteen of the fifteen CNM practices in New Mexico were started in 1997 and rapid expansion continues. There is also a partnership with University of New Mexico Hospital (UNMH) to bring prenatal care to urban medical indigents through the Maternal and Infant Care Project.

Health and Health Related Services to Children: Affordable and quality childcare is an identified need in every county in New Mexico. County MCH Councils work locally to improve access to providers and to provider training, and staff of the MCH Unit work with the Department of Children Youth and Families to provide technical assistance for health and health related issues in childcare. Community-based Head Start and Early Head Start programs are important local resources for many of the most vulnerable families in New Mexico. There is an identified need for more state-based technical assistance to meet the needs of these programs that can have lasting impact on the lives of children and families.

New Mexico's Title V MCH staff provides intensive technical assistance in the areas of community assessment, health and health related components, and family partnership should additional Head Start technical assistance resources become available. Access to healthy food is another critical factor in child health and development, but children and their families do not have access to standardized nutrition screening, assessment and counseling. Due to Division staff reductions, there is currently no MCH Nutrition position to develop the statewide system of community-based, family centered nutrition services for children and their families.

A valiant effort was made to provide technical assistance to a variety of individuals and groups in an effort to use tobacco settlement funds to expand home visiting services to first time parents. The Governor vetoed the recommendations of this program.

Childhood Injury Prevention Program staff worked on traditional use of seat belts, infant car seats and use of helmets for cyclists. It is also involved in environmental issues affecting children such as pesticides, radon, nutrition and childhood asthma triggers.

MCH Epidemiology has a medical epidemiologist assigned to PRAMS and a epidemiologist-coordinator for MCH death review. A small team is forming, thus putting the MCH Program in a stronger position to conduct comprehensive assessment, surveillance and evaluation in coming years.

Public Health Division Integrated Information System Title V funds were used in FY96 to sponsor technical assistance for development of the planning document and the retreat-setting work sessions. The MCH Epidemiologist served on the Steering Committee throughout development, and selected Program Managers gave between 20-40 working days in FY98 to contribute to a statewide Joint Application Design (JAD) process producing specifications for a new system. A contract was awarded to build a new system. Progress is described in Section 4.1, the Annual Plan. In addition, an Internet site for the NM Department of Health is in development and will feature pre-programmed data sections of key DOH indicators for MCH, for state and community level users.

The WIC and Commodity Supplemental Food programs are now located in the Family Health Bureau, affording closer coordination of services to mothers, infants and children, including CSHCN. Final piloting of the new information system is proceeding successfully. The WIC Program is implementing the addition of a WIC Smart Chip to the food stamps electronic benefits card, which will allow greater flexibility in purchase of food package and greater capacity for tracking fund use. The new information system will provide increased data on health status of the MCH population. The many WIC sites have been extremely helpful in distributing components of the “From Day One” and “Say Yes to Healthier Kids” parent education materials.

1.5.1.3 Other Capacity:

Children’s Medical Services: There are ll7 staff in 32 field offices along with the state department. The Management Analyst and Staff Development Specialist positions are vacant and frozen and the FIT Clerk Specialist position in District I is in the process of being transferred to State Office. New staff include: Lynn Christiansen, Program Manager 2B, Kimberly Ledet, Administrator 3, Elisa Martin, Planner 3, Carol Brewer, Financial Specialist 2, Renee Cordova, Clerk Specialist Supervisor, and Christine Gallegos, (Manager 2) Clinics Coordinator. The CMS program continues to work closely with Family Voices and maintains a $20,000 annual contract with Parents Reaching Out (PRO), a statewide parent organization for parents of CSHCN. Family advocates (parents or individuals with disabilities) participate in pediatric specialty clinics and receive an honorarium for this participation. Many staff are also parents of CSHCN.

MCH Unit: 10 staff, Victoria Parrill, Program Manager, Roberta Moore, Nurse 5E, Vacant, Administrator 2, Doreen Sansom, Public Health Educator, BJ Butler, Manager 5, Nancy Treat, Planner 3, Denise Vigil, Financial Specialist, Viola Romero, Clerk Specialist, Vicki Howell, Vital Records and Health Statistics Analyst, John McPhee, Child Violence and Injury Prevention Coordinator .

Family Planning Program: 15 state office staff: Lynn Mundt, MBA, Program Manager; Ben Naranjo, Planner; Fermina Najera, Financial Specialist; Vacant, Secretary; Erin Johnson, Health Educator; two vacant positions for Health Educators in male involement and teen pregnancy prevention; Joahnnaz Connolly, 0.5 FTE; vacant, Health Educator; Margie Montoya, Nurse Liaison; Ruby Marquez, Nurse Liaison; Vacant, Nurse Liaison; Phil Sweeney, Systems Analyst; Ssu Weng, MD, Medical Director; BJ Thomas, Management Analyst; vacant, Staff Development Specialist.

Adolescent Health: Program Manager, Karen Gaylord; Public Health Educator, vacant; Program Secretary, Helen Montano; and a contracted Youth Development Coordinator works 28 hours weekly From November 1999 to the present, the Public Health Educator position was vacant due to freezes. In May 2000, the position was posted for hire with an anticipated fill by July. The seven-month vacancy has severely compromised the Unit's capacity to meet its FY 00 objectives. The Needs Assessment as originally designed is only half completed and the full report on the status of the health, well being, safety, protective factors and employment of adolescents in NM was postponed. Important collaborative partnerships with other State Agencies was limited as was the technical assistance to communities.

Families FIRST: 6 state office staff, Penny Jimerson, Program Manager; Julie Colton-Nash, Social Worker Consultant; Charlotte Romero, Nurse Consultant; Milee Rotunno, Management Analyst 4, Jessica Marquez, Management Analyst 2 and Ruth Gonzales; Clerk Specialist. District FF Coordinators: District 1 Kathy Casaus, District 2 Carla Gordan, District 3 Pam Harris, District 4 Debra Belyeu.

MCH Epidemiology Program: Susan Nalder, EdD, MPH: Program Manager, David Broudy, PhD, MPH: Since Sept 1998, Epidemiologist, lead responsibility for maternal, fetal, infant and child mortality and fatality Epidemiology including Maternal Mortality Review, Child Fatality Review; Ssu Weng, MD, MPH, Epidemiologist, lead responsibility for NM Pregnancy Risk Assessment and Monitoring System (PRAMS); Dorin Sisneros, Operations Manager, NM PRAMS; Pam Rodriguez, Clerk Specialist, NM PRAMS.

1.5.2 State Agency Coordination

The NM Title V programs have an extensive network of federal, state and local partners who are essential to implementation of services and programs. The matrix that follows illustrates these partnerships:

Direct Medical Services

52 Local Health Offices in 4 Districts, provide MCH services as needed such as prenatal care, well child care, family planning, immunization, pregnancy testing, Healthier Kids Fund, and services for CSHCN. Local Health Offices are important partners in information and referral to resources

The Maternal and Infant (M&I) Project at UNM is contracted to close gaps for the under-uninsured in metropolitan Albuquerque and provides prenatal, postpartum and family planning clinical services; infant health services.

The Dept. of Pediatrics at UNM provides follow-up services to Newborn Intensive Care Unit infants and families

High Risk Prenatal Care Fund provides funding for private providers of high risk prenatal care to give services to medically indigent women.

County MCH Plan Act funding provides direct maternal and child health services to fill identified needs.

Primary Care Centers, including federally qualified in medically underserved areas

Medicaid Family Planning Waiver implemented in FY98; the Family Planning 1115 Medicaid Waiver extends Medicaid covered family planning services for two years uninterrupted to all

women over 18 years of age at 185% of poverty. To date, over 16,375 women have enrolled in this new service.

NM School Mental Health Initiative to break down barriers to student's learning with an emphasis on meeting children's mental health needs.

Early Intervention Programs provide nutrition services to children at risk for developmental delay

CMCHPA funding provides direct maternal and child health services to fill identified needs.

Healthier Kids Fund of CMS, provides primary care to uninsured or underinsured children, administered by CMS program (now closed to new enrollments due to financial limitations).

County MCH Councils are engaged in activities throughout the pyramid. Specific actions are based on priorities in the County MCH Plans. The County MCH Plan Act provides funding for direct maternal and child health services to fill identified needs.

CMS sponsors pediatric specialty clinics through contracts or provider agreements with pediatric specialists and ancillary staff.

Enabling Services

Local Health Offices are important partners in information and referral to resources

WIC, statewide nutrition education and food supplementation services to pregnant women, infants and children

Families FIRST: is involved via:

- ✓ The three Medicaid MCO's (Cimarron, Lovelace and Presbyterian) in conjunction with their prenatal provider network to improve NM's rate for first trimester prenatal care.
- ✓ Human Services Department to increase referrals from Income Support Division to FF at the time of Medicaid enrollment.
- ✓ Children Youth and Families Department provided training at the Statewide FF meeting on child abuse/neglect identification and reporting.

NM Coalition against Domestic Violence has received a grant from the Frost Foundation to train FF case managers in the identification and management of domestic violence among pregnant women.

Care Management, transportation, and interpretation services provided by CMS for CSHCN and their families

The Emergency Medical Services Program supports perinatal transport

Medicaid Salud! consults with MCH for development of criteria to address CSHCN issues in upcoming RFP

CMCHPA funding provides transportation services to meet identified needs

The Advisory Committee for the Prevention Focused Service System for Children at Risk for Developmental Delays

CHOICES (Shriner's), community based follow-up for CSHCN discharged from Shriners Hospitals

CSHCN Contract with Parents Reaching Out (PRO) and relationship with Family Voices through MCH Collaborative

CSHCN advocacy groups address SSI re-determination and other CSHCN issues, information needs, and parent/professional partnerships including Training for Advocacy for CSHCN.

WIC in offices statewide does presumptive eligibility for pregnant women and distributes Day One and Day Two books to mothers of infants along with WIC services, nutrition education, etc.

Navajo WIC - distribution of Day One books to mothers of infants

CMCHPA funding provides transportation services to meet identified needs

County MCH Councils actions are based on priorities in the County MCH Plans. The County MCH Plan Act provides funding for direct MCH services to fill identified needs.

Department of Health Substance Abuse Prevention Initiative, a community based program, will provide grants to community groups to provide prevention services focusing on youth.

Population Based Services

New Mexico Outreach- social marketing for MCH Populations - partnership with Medicaid and private sector in areas of prenatal care, family planning, teen pregnancy and violence prevention, early childhood development, and newborn genetic screening

Not Even One, a project of the Carter Center, investigates all firearm-related deaths in Santa Fe and Albuquerque using a methodology similar to FIMR that includes community action.

NM Maternal Mortality Review (MMR), NM Child Fatality Review (CFR) Fetal and Infant Mortality Review (FIMR), NM Pregnancy Risk Assessment and Monitoring System (PRAMS) Steering Committee and NM Birth Defect Prevention and Surveillance System (BDPASS) Advisory Committee have multi-disciplinary membership from across DOH groups, UNM teams and departments, IHS, Native American tribal government, statewide networks of community groups, children's advocacy groups, and other state agencies

Infrastructure Building

NM Families FIRST, a case management program for mothers and infants, has contracts with the three Medicaid MCO's and was named the delegated authority for perinatal case management for SALUD members statewide starting July 1998. Expansion of Family First Providers from 16 to 64 using staff from local health offices and providers across the state.

NM PRAMS Steering Committee and NM BDPASS Advisory Committee have membership from university, Indian Health Services (IHS), Native American government, community groups, other state agencies

Hear Early Advisory Council, to address newborn hearing screening

CMS Medical Advisory Committee

Rocky Mountain States Regional Genetics Network

Interagency Coordinating Council for Early Intervention, IDEA, Part C

CNM Advisory Board and Licensed Midwifery Advisory Board: these boards comprise private and public sector professionals, oversee clinical practice, standards and other activities required by regulations

NM WIC in collaboration with federal funds and county government built modular facilities to extend services in rural communities [Dona Ana and Picacho, in Dona Ana County].

NM WIC has completed a $5 million project to decentralize electronic WIC information; this client system includes EBT or "smart card" capability and is considered a prototype for the NM DOH's integrated client system project now in development.

CNM Advisory Board and Licensed Midwifery Advisory Board: these boards comprise private and public sector professionals, oversee clinical practice, standards and other activities required by regulations

MCH and PHD staff coordinate the MCH Overview course in the MPH program at UNM

Medicaid partners with MCH to develop social marketing products to reach teens, pregnant women, new parents, to promote male involvement, and to promote early childhood development

NM Youth Development initiative with emphasis on Youth Development, Assets and Resiliency assessment and planning initiatives

Partnerships for Special Nutrition have membership from advocacy groups of parents of children with special dietary needs, private non-profit agencies, and state agencies

CMCH Planning Councils have members from provider, consumer, and business groups, and are representative of the ethnic and geographic diversity of the counties.

Statewide Children's Health Insurance Program (SCHIP): Steering Committee and Subcommittees are composed of staff from the NM Departments of Health, Children Youth and Families, and Human Services, community-based providers, and consumers.

County MCH Councils are engaged in activities throughout the pyramid. Specific actions are based on priorities in the County MCH Plans. The County MCH Plan Act provides funding for direct maternal and child health services to fill identified needs.

New Mexico LEND Program-UAP/UNM and CMS have a strong partnership working on cultural competence and medical home training

CMS, Disability Determination Services and Social Security Administration meet quarterly to share new initiatives and data.

II REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures: The Title V programs continue to refine expenditures in each level of the pyramid. This may account for minor discrepancies from year to year.

2.2 Annual Number of Individuals Served

2.3 State Summary Profile

2.3 **Progress on Annual Performance Measures:** The New Mexico Title V Program uses comprehensive planning grids to show performance measures, targets, and the relationship of program activities to the accomplishment of each performance measure. The report grids for the period ending June 30, 1999 are presented in the following pages.

PM 01	**Performance Measure 01:** The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. **Healthy People 2000 Objective:** Objective 17.20 Capacity/Direct Health Service

Public Health Situation or Problem: Children under the age of 16 years may not be receiving the services they need despite being on Medicaid.
Contributing Factors: The service delivery system is fragmented and complex; these populations' medical needs are being addressed in a Medicaid Managed Care model.

Measure and Status:	**1996**	**1997**	**1998**	**1999**	
State Target	na	na	5%		
State Performance	na	na	5%	7.5%	
No. served CMS			299	420	(40% Incr.)
No SSI Children	6914	5895	5824	5610	

Significance: Title V legislative requirements mandate the provision of rehabilitative services for blind and disabled individuals under the age of 16 receiving benefits under the SSI Program to the extent medical assistance for such services is not provided by Medicaid. The Title V responsibility for providing and promoting family-centered, community-based care serves as a basis for States to establish a policy whereby all SSI disabled children are eligible to participate in or benefit from the State Title V CSHCN Program.

Data Source: The Social Security Administration
Data Issues: The Social Security Administration can only report on children receiving SSI who are age 18 and under.

Annual Performance Objectives: 7/1/98-6/30/99	**Activities**	**Progress on Indicators: 6/30/99**
1. Insure that all children on SSI under the age of 16 years have information on the services provided by the Children's Medical Services Program.	1. Notify families of children < under the age of 21 years who were approved for SSI benefits, of services provided by the CMS Program, and assess their ability to utilize resources available to them through SALUD. 2. Continue working with the SSI Advocates Group to insure that families understand the SSI changes, appeal procedures and assist them to negotiate the system.	1. The number of children < age of 16 years, receiving SSI benefits, who were contacted by the program. 60% of children on SSI as new approvals have received information on available CMS services. 2. The number of children/families denied SSI benefits were contacted. Mailing to SSI denials were done from the state office during the reporting period with the best data available.

PM 02	**Performance Measure 02:** The degree to which the State CSHCN Program provides or pays for specialty and subspecialty services including care coordination, not otherwise accessible or affordable to its clients. Healthy People 2000 Objective: 17.20–Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions. Capacity/Direct Health Service

Public Health Situation or Problem: CSHCN need a comprehensive system of care coordination in addition to traditional services paid for including medical, habilitative and rehabilitative services, equipment and assistive technology. And compassionate care. **Contributing Factors:** The state is large, rural, sparsely populated with an inadequate number and an unequal distribution of service providers. **Significance:** The care coordination function is critical to assure that families and their CSHCN have access to needed health care in a comprehensive and timely manner	**Measure and Status:** **1996** **1997** **1998** **1999** State Target 8/9 8/9 8/9 8/9 State Performance 8/9 8/9 8/9 8/9 Checklist of 9 categories of service: Medical and surgical sub specialty services; OT, PT services; Speech, hearing and language services; respiratory services; durable medical equipment and supplies; home health care; nutrition services; care coordination; and early intervention (EI) services. NM at 8/9; EI managed by LTC Division, DOH

Annual Performance Objective: 7/1/98-6/30/99	**Activities**	**Progress on Indicators: 6/30/99**
1. Increase to 100% the number of CHSCN who have access to a list of services, and other information about the program.	1. Assure that all CSHCN have access to the checklist of nine services and information about the program.	1. The number of CSHCN for which the 9 services are provided or coordinated was 6581 CSHCN or 100%.
2. Increase to 100% the number of CSHCN identified as eligible for Title V Program and are participants in needed areas of service: a. Medical services b. OT, PT services c. Speech, hearing and language services d. Respiratory services e. Durable medical equipment and supplies f. Home health care g. Nutrition services h. Care coordination i. Early intervention services	1. Maintain current areas of reimbursement (items a-i) on checklist. 2. Increase efforts of nutrition screening and referral for services, as well as nutritionists working in CMS clinics. 3. Continue care coordination which is provided by CMS staff and available to all CSHCN and their families. 4. Strengthen linkages to early intervention services and Part C program.	1. CMS eligibles receiving identified services was 6581 or 100% 2. CMS nutritionists and the children include 4 nutritionists serving 100% of children. Also provide consultation in the local communities including. Nutritionists provide screening in CMS sponsored medical specialty clinics. 3. CMS eligibles receiving care coordination services is 100% of 6,581. 4. CMS staff focused on Part C activities and children served include 12 social workers and 6 clerks serving 433 children birth to three during this period. FIT social workers are involved in on-going community coordination efforts with early intervention services and other providers.

PM 03	**Performance Measure 03:** The percent of CSHCN in the State who have a "medical/health home" Healthy People 2000 Objective: 17.20 Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions. Capacity/Enabling

Public Health Situation or Problem: CSHCN need a "medical/health home" in order to have accessible, continuous, comprehensive, family centered, coordinated and compassionate care. **Contributing Factors:** The state is large, rural, sparsely populated with an inadequate number and an unequal distribution of service providers. **Significance:** The morbidity and mortality of CSHCN without a medical/health home puts them at higher risk for complications and lower quality of life. Care provided in a pediatric or family practice based setting provides coordination which is not available in a fragmented system of emergency and walk-in care.	**Measure and Status:** **1997** **1998** **1999** **2000** National/State Target 80% 81% 82% State Performance 78% 80%

Annual Performance Objective: 7/1/98-6/30/99	**Activities**	**Progress on Indicators: 6/30/99**
1. Increase to 85% the number of CSHCN who have an identified "medical/health home."	1. Determine the number of children with a "medical/health home."	1. 82,640 CSHCN with an identified medical/health home.
2. Increase to 50% the number of families with CSHCN who report a high level of understanding the significance of a "medical/health home," and feel they are utilizing it to meet their children's needs.	1. Utilize information from focus groups and needs assessments to identify families understanding and use of their child's "medical/health home."	1. Reports from Focus Groups reflected a priority of each child having a primary care physician but not necessarily all of the components of medical home. There have been many changes in the medical community from Managed Care Medicaid to a significant number of physicians changing practices in the county where focus groups were held.. 2. Reports through surveys and needs assessment data gathering efforts. A survey of 300 families was conducted around the issue of Medical Home in Dona Ana county and parents did not report significant gaps in the availability of the components of medical home.

PM 04	**Performance Measure 04:** Percent of newborns screened by State sponsored programs for genetic disorders and other disabling conditions. Healthy People: 14.15 Increase to at least 95% the population of newborns screened by State sponsored programs. Risk Factor/Population-based

Public Health Situation or Problem:	**Measure and Status:** The percent of newborns in the state with at least one screening for each of PKU, Hypothyroidism and galactosemia.
Genetic disorders not detected and treated early in life will result in retardation, institutionalization or death. Contributing Factors: Genetic inheritance, congenital mutation, delayed detection and treatment.	Year: 1995 1996 1997 1998 1999 Target % Newborns: 100 100 100 100 100 State Performance: 102.9 99.18 99.39* ** Live Births 26226 28840 **New Data for FY 98 not available. CAH added to screening 8/98 * 1997 corrected total. See note on 2.4 PM 4 re: data analysis

Annual Performance Objectives: 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999:**
1. Decrease the number of unsatisfactory specimens submitted by hospitals with consistent rates above average	1. Provide in service training on specimen collection to hospital nursery and laboratory staff. Maintain/update CE course for nurses. 2. Focus attention on training on targeted problem areas. 3. Evaluate training effectiveness	1. Zero trainings held. There was a 6 month gap in hiring new staff to complete training with hospitals. Training materials were updated for new conditions in screening program but no trainings were actually held until FY00. 2. System established. A system for reducing specimen errors has been developed but the SPPS itself is not operational.
2. Enhance awareness of Newborn Genetic Screening Program among health care professionals.	1. Publish quarterly newsletter 2. Revise CEARP course for nurses made available statewide.	1. Newsletter sent out in November 1998. Due to staff transition and vacancy no new newsletters were sent out. b. CE course utilized. Due to staff transition and vacancy, no courses were held during the reporting period.
3. Improve data system for linking births and newborn genetic systems and screening practice profiles system.	1. Collaborate with Vital Records/Epi to establish system. 2. Explore software to support SPPS system.	a. Establishment of system will occur in FY99. Collaboration with Vital Records was initiated but has not been completed. b. Will occur in FY99. The matching system is still being developed. A match was completed with a 94% match rate for CY 97 births but a re-match was not completed during the reporting period.

*SLD unable to provide data on unduplicated screens thus the percent for 1998 is greater than 100%.

PM 05	**Performance Measure 05**: Percent of children who completed immunizations for Measles,Mumps,Rubella, Polio, Diptheria,Pertussis,Tetanus, Hemophilus Influenza, and Hepatitis B by age 2; HP 2000 95% of children completed full immunization schedule by 2nd birthday Risk Factor/Population-Based

Significance: Lack of immunizations can lead to complications of disease; Barriers to immunizations include attitudes, access to services and referral linkages between programs.

Measures and Status:

	1994	1996	1997	1998	1999
State Target	%	68	70	75	75
State Performance	58	63	64	78	73
CDC Survey					

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Establish statewide immunization information system whereby all participating providers can determine and report immunization status of children 0-6 with linkage to central database	1. Finalize business plan. 2. Develop request to legislature for funds to implement system.	Plan developed but no implementation funds obtained.
2. Total enrollment of 460 VFC providers	1. Continuos recruitment of VFC providers	400 VFC providers enrolled.
3. 85% of Families First clients 0-2 will have up to date immunizations according to the current schedule during the first year of life.	1. Develop a system to monitor immunization rates FF clients 0-1	1. Information to collect immunization rates incorporated into the FF pediatric evaluation component. 2. Data on percent of FF children with complete immunizations at one year of age is not available due to changes in the Division's computer system.
4. Community based activities will be incorporated into State Title V Program planning to achieve performance objectives.	1. The SSDI project will share the State Title V performance measures and planned achievements with CMCH councils to identify local strategies.	County MCH Councils provide community based support for awareness and outreach activities.

06	**Performance Measure 06:** The rate of births to female teenagers aged 15-17. **Healthy People 2000 Objective:** Related 5.1 Reduce pregnancies among females aged 15-17 to no more than 50 per 1,000 females aged 15-17. Increase to at least 90% the proportion of sexually active, unmarried people, aged 19 and younger, who use contraception, especially combined method. Risk Factor/Population Based

Public Health Situation or Problem: intended/unintended pregnancy in teens resulting in welfare dependency, school dropout, parenting problems and child abuse.
Contributing Factors: access/use of sexual/reproductive health information; values that promote/do not prohibit teen pregnancy; sexual abuse in family settings; poverty; community denial re teens and sexual involvement; expressed desire to parent as teens; parental/political barriers re curricula on human sexuality/birth control in schools.
Significance: DHHS is making teen pregnancies a priority goal (a major threat to healthy and productive lives) in their 1997 strategic plan. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

Measure and Status:

	1992	1993	1994	1995	1996	1997
Target:		50	50	50	50	47
State Performance:	51.2	54.0	53.5	51.0	48.0	NA

Birth rates in teens 15-17/1000 pop. May be showing a decrease; national target has been met but needs to be monitored for a longer period of time to assess for real trend.

Data Source: New Mexico Vital records are the source of data on mother's age and births.
Data Issues: Population special needs

Annual Performance Objectives: 7/1/98 – 6/30/99	Activities	Progress on Indicators: 6/30/99
1. To provide appropriate education in local Communities.	Staff from at least 14 FP sites will provide education on sexuality, preventing unintended pregnancy and violence, contraception, etc;	Presentations: 290 Elementary School Students: 2495 Middle School Students: 4811 High School Students: 3675 Total # Students: 10981 Pamphlets distributed: 90,000, Videos: 145
2. To network within the community.	9 FP sites network w/ community groups to develop a plan for interventions around teen issues; Cover topics such as: Pregnancy and violence prevention, STD's, youth development, abstinence, gangs, substance abuse, school based clinics, nutrition, disabilities, ECP's, auto safety, mental health, teen dropouts, peer counselors, library usage.	Community groupsYouth, Family, Religious, Colleges, Community, Human Services/Other Health Providers, Law/Courts, Business Outcomes: Health fairs, grant applications, youth conference, home visiting, red ribbon campaigns and parade, life skills curriculum, mobile clinics, rape crisis team, teleconference, promotion of teen hotline, field trips, summer programs, Pride Project, parenting classes, church collaboration.
3. To network in within the school community	Staff from 4 FP sites network w/community school administrators, boards, teachers and nurses to address interventions re teen pregnancy; State Office will collaborate w/other state programs reaching schools	Total # of Schools: 188 Elementary 121, Middle 74, High School 105. Total times contacted: 867 Topics: Pregnancy and violence prevention, STD's, youth development, abstinence, gangs, substance abuse, school based clinics, weight

		management, mental health, sexuality education curricula, date rape, anger management, holistic health, Tai Chi, "Good/Bad and Healing Touch", high risk behavior, parenting, condoms, self image. Outcomes: Health fairs, monthly meetings, teen pregnancy conference, life skills curriculum, teleconference, summer programs, and Pride Project. Collaboration with day care centers, crisis intervention programs, peer counseling, school nurses, cycle of life bracelets, mediation, teen referrals, community partnerships, school based clinics, 24-hour counseling service, school health advisory councils, Individual Performance Plans, collaboration with teen health centers, Teens Need Teens Program, collaboration with St. Joseph's Health Care "Super Sitter" Program. Collaboration with other state programs: 11 Pamphlets: 72,000 ; Videos: 30; Curricula: 2
4. To provide community awareness/outreach, presentations, and media.	Staff from 24 FP sites will provide educational sessions through community-based organizations (other than schools); Support comm. based orgs and schools by providing funds for teen pregnancy Prevention programs to implement abstinence education; Support statewide and comm.-based media campaigns focusing on abstinence from sexual activity.	Total organizations contacted: 187 Total education sessions: 344 Total age <18: 1928 Total age 18 and >: 2288 Topics covered: Anger management, "Wonder of Myself", hand washing, nutrition, diabetes, date rape, immunization, safe sex, teen pregnancy, STD's, violence and suicide prevention, FP, teen shelters, harm reduction, ECP, physicals. Types of Organizations: Youth, families, religious, colleges/universities, communities/civic leaders, neighborhood, human service or health provider agencies, law enforcement/courts/detention, and business.
5. To provide specialized teen clinic services.	28 clinic sites will provide specialized clinic hours and services for teens aimed at reducing pregnancies among this population; Provide workshop segment annually addressing teens, collect clinic schedules, provide staff training and educational materials;	8 sites offer special hours for teens. State Office provides TA for adolescent issues. Contracts: 3 PA's: 16 Provider Agreement sites have teen focus..

	Clinical contracts and PAs will focus on teens	
6. To increase staffing in areas of high need.	State Office staff seek Federal and State funding sources to add staff in areas of high need contingent upon funding availability and State policy.	Family Planning Program was awarded funding and thus hired a Teen Pregnancy Prevention Health Educator 2 Position and 1115 Waiver/Preconception/VAST Health Educator 2.
7. To assess needs of high-risk teens.	At least 3 sites will use assessment techniques such as focus groups and surveys to determine local needs or appropriate interventions for high-risk teens. State Office will be involved with the youth resiliency effort.	Focus groups: 18 Participants: 720 Needs identified: Planned intervention Surveys distributed: 2000 Total # of surveys collected: 1499 Return rate: 75% Contracts: 21
8. To assure high quality services are provided and evaluated.	A 5 year site evaluation schedule will be followed. State Office teams will conduct site visits to at least ten local health offices per year. State Office staff will continue to develop and implement a system for monitoring PA sites. State Office staff will continue to develop and implement a system for monitoring contractor sites	In 1999 10 Local Health Offices, 2 Clinical Contractors and 11 Provider Agreement sites had full site visits from State Office Staff utilizing the Region VI Tool. 10 Male Involvement sites received site visits from State Office staff.

PM 07	**Performance Measure 07:** Percent of 3rd grade children who have received protective sealants on ≥ one permanent molar tooth. Healthy People 2000: 12.8 Increase to > 50% the proportion of children aged 8 years who have received protective sealant on the occlusal (chewing) surface of permanent teeth. Risk Factor/Population-based	
Significance: Twenty five percent of children have eighty five percent of the dental caries. **Contributing Factors:** Family income, education, families' unaware onset of disease, lack of access to care, low numbers of pediatric dentists/dentists treat children.	**Measure and Status** 2000 Target 50.0% Estimated % 3rd graders w/sealant 42.2% This population-based measure was assessed by the dental program through a statewide survey in FY 2000	
Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Ensure adequate # and distribution of school-based sealant providers.	1. Provide school-based sealant program using DOH, and contract staff. 2. Explore Medicaid in the schools as a funding vehicle for school-based sealants	Number of public elementary schools participating in DOH Sealant Program: 119 Number of 2-3 Graders served by DOH Sealant Program: Number of public elementary schools participating in Albuquerque Contract Sealant

		Program: 79 Number of 2-3 Graders served by Albuquerque Contract Sealant Program: 1463 Dental Director made 14 presentation to DOH, HSD and DOE staff on the concept of using MITS to fund dental services.
2. Ensure sealant placement in under-served areas using a clinic-based strategy.	1. Include payment for sealants in DOH contracted service providers; motivate I.H.S./FQHC's/Rural Clinics to provide sealant; 2. Motivate private sector to provide sealants;	Sealants included as authorized services in DOH contracts. I H S focuses on sealants, FQHC's/Rural clinics were contacted regarding sealant placement.
3. Establish methodology for collecting sealant placement data for 3rd grade children state-wide	1. Secure sealant data from I.H.S; 2. Secure sealant data from MCO's; 3. Consult with dental insurance carriers to secure these data from non-Medicaid recipients	State-wide oral health survey conducted in FY 2000 revealed a sealant rate in 3rd grade students of 42.2%.
4. Ensure use of Fluoride mouthrinse in schools located in communities with sub-optimal levels of Fluoride in the water	1. Identify schools with students at risk and not participating in Fluoride mouthrinse programs; 2. Motivate schools with students at risk and not participating to adopt the mouthrinse program; 3. Monitor mouthrinse program by visiting 20% of the schools with mouth- rinse programs; Report on mouthrinse program status annually; Survey caries prevalence in 3rd graders.	Number of schools participating in mouthrinse program: 1 Number of students served: 23,114 Caries prevalence in 3rd grade students state-wide: 64.5%.

SP 08	**Performance Measure 08:** Rate of deaths to children age 1-14 caused by motor vehicles. Healthy People 2000: Reduce the rate to no greater than 3.5/1000 age 1-14. Risk Factor/Population Based

Significance: NM data shows a failure to use seat belts and appropriate toddler restraints; alcohol in adult or teen drivers, SUVs. **Contributing Factors:** Lack of adequate transportation for size of family, lack of child car seats, inappropriate number of passengers in vehicle, lack of concern about alcohol consumption; lack of appropriate seat belt laws; inadequate driver training	**Measures and Status:**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
	Target	**3.5**	**3.5**	**3.5**	**3.5**	**3.5**	**3.5**
	State Performance.	**6.5**	**9.0**	**10.1**	**9.6**	**7.3**	**7.9**

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Provide promotion, coordination and oversight of overall childhood injury prevention program, including the SAFE KIDS contract, workshops, media events, and public speaking engagements	1. Use CFR and 10 yr trend analysis data and information to produce "best practices" program information and media messages. 2. Identify appropriate venues for distribution of information. Hire statewide SAFE KIDS coordinator and attend National SAFE KIDS Conference.	1. Trend analysis updated and distributed. 2. Statewide SAFE KIDS Coalition reorganized, with new protocols, committees, and bylaws, clarifying its relationship with nonprofit sponsor. Contacts for receipt of information updated in statewide database. New coordinator hired and trained.
2. Produce risk reduction, prevention and systems improvements information for 1998 deaths via the transportation panel of the CFR, National SAFE KIDS data, and Children's Safety Network data. Also produce review of the 10 year trend (1987 to 1998), including identification of gaps and discrepancies	1. Use CFR special panel to assess all factors, complete case files and produce written report. Consult with Children's Safety Network and National SAFE KIDS about national trends in data and best practices for primary prevention. 2. Advocate for graduated licensing law, interlock device use for all drivers. 3. Increase statewide SAFE KIDS Coalition participation specifically in the area of occupant safety for children.	1. Transportation panel of CFR continues to work and produce summary information. National SAFE KIDS and Children's Safety Network information comprehensively discussed, evaluated, and distributed. 2. Graduated licensing law and an interlock law approved by Legislature. Increased participation statewide in occupant safety for children.
3. Provide car seat technician trainings, distribution of free/discounted car seats, inspection and removal of defective car seats, and printing or purchase, as well as distribution of, occupant safety literature and posters via the childhood injury clearinghouse	1. Solicit federal, state, city, and private funds for the purchase of car seats, production of car seat events, production of car seat technician trainings, and acquisition of safety literature and posters	1. Gaps identified, and clearinghouse continues to expand. 24 car seat clinics produced; 16,000 clearinghouse newsletters and 10,000 occupant safety brochures/posters distributed; increased volunteer hours in SAFE KIDS Coalition; 15 one day car seat advocate trainings and 3 four day technician trainings.
4. Make seatbelt and occupant safety trainings for medical, public health, and EMS personnel a priority with statewide car seat distribution system.	Collaborate with hospitals, EMS providers, and public health offices to promote car seat technician training.	Significant increase in professional medical trainings resulting in an increase of certified technicians from 5 in '97 to over 50 in '98.

PM 09	**Performance Measure 9:** The percent of mothers who breastfeed their infants at discharge from hospital Healthy People: 75% of mothers breastfeed in early postpartum; 50% continue to infant age 6 months. Risk Factor/Population-based

Significance: Excess health care costs are associated with formula feeding. Breastfeeding is critical to optimal growth and development of babies. Barriers to breastfeeding exist in the knowledge, skills and behaviors of health care professionals, day care providers, employers, and family members, as well as the pregnant or postpartum woman herself. Multiple gaps in the support system for breastfeeding mothers do not allow for informed choice in the matter of infant feeding.

Measures and Status:

	1996	**1997**	**1998**	**1999**	**2000**
Target	71%	72%	73%	74%	75%
Ross Lab Survey	72.5%				
WIC mothers	63%				
NM PRAMS*			74%	75%	

* 1997 data includes July –Dec 1997; 1998 data includes the half of 1997 and all of 1998.

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Compile WIC and PRAMS data to for assessment and planning purposes.	Analysis of breastfeeding data in PRAMS planned by L. Albers at UNM	PRAMS analysis complete for 97-98. WIC analysis schedule completion Fall 2000.
2. Increase % NM WIC mothers who initiate and continue breastfeeding	New Mexico Breastfeeding Task Force will identify and evaluate strategies to improve the statewide system for breastfeeding support	a. Increased peer counselor sites from 5-6 b. Participated in national USDA breastfeeding "Loving Support" campaign, including media campaign and client education c. NM Breastfeeding Task Force: successfully advocated for legislation protecting a woman's right to breastfeed in public and provided education and technical assistance to businesses and restaurants on implications of the law.

PM 10	**Performance Measure 10:** Proportion of newborns who receive hearing screening. Healthy People 2000 Objective: 17.16 Reduce the average age at which children with significant hearing impairment are identified. Risk Factor/Population Based

Public Health Situation or Problem: The average age for detection for hearing impairment in the USA is 2 years. **Contributing Factors:** The state is large, rural, sparsely populated with an inadequate No. and an unequal distribution of service providers.	**Measures and Status:** 1996 19971998 1999 Target 100% State Performance 82% 90% 97% 98% 99% of hospitals participated in FY99 [all but one community hospital]

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Increase the number of birthing hospitals who are universally screening to 100%.	1. Assist the one hospital not universally screening to begin screening with the completion of the new Children's Hospital in the city.	1. All but one hospital is screening all newborns before discharge. In the area where this hospital is located there is an Air Force Base with a pediatric clinic. This clinic is screening 50% of the newborns delivered at the hospital within 2 weeks of birth.
2. Increase the number of referrals who receive re-screenings.	1. Verify the number of re-screenings and the "drop-out rate" from referral upon discharge to the number receiving re-screenings.	1. Proportion of referrals that receive re-screenings at the hospital or other sites. Data unavailable for entire reporting period.
3. Increase the number of referrals who receive diagnostic evaluations.	1. Fully implement the tracking system with feedback from CMS staff. 2. Prepare reports for hospitals and CMS from monthly diskettes received on all screens.	1. Tracking system is inclusive--screening hospitals send data from screenings each month. For reporting period the referral rate at discharge was 8%. 2. Mo. reports are prepared anddistributed to each hospital including a listing of infants who needs re-screens ; 3. % referrals that get an evaluation--50% of infants with a referral at discharge receive a re-screen and 50% are lost to follow up; 4. Compare % infants actually screened to no newborns in the hospital for reporting period and reconcile w/reports of discharged without a screen—the CY99 birth file has just been made available to the program and these comparisons were not made during the reporting period.
4. Identify system/process of transition from screening to diagnostics.	1. Distribute manual for CMS staff use in implementing the transition from screening to diagnostic process. 2. Provide training. 3. Develop an early intervention referral	1. Policy and procedure manuals were distributed to CMS staff, Step Hi staff, hospital staff and others requesting them. 150 manuals distributed 2. No. of training sessions—six training

	system.	sessions were held with CMS staff on program protocols and follow up system. 3. An E.I. referral system is in place. This referral system uses the FIT social workers who work with families of children under 3 with developmental delays. Information on placement and tracking is not yet complete.
5. Decrease false positive rates by decreasing refer rate before discharge. (Target is <5%).	1. Encourage at least one re-screening before discharge. 2. Encourage one-two week follow up for re-screens by hospital if possible. 3. Strengthen follow up system from monthly reports to identify problem areas.	1. All hospitals are re-screening at least once before discharge and 75% of them are re-screening twice before discharge. 2. There is approximately a 2 month time delay for infants not re-screened at the birthing hospital after discharge. 3. A follow up system is in place to work with the hospitals using the monthly reports. Referrals are made to CMS local staff for linkage with families. Many of these families are very difficult to find, and while a system is in place, 50% of referrals are lost to the system. Visits are made to hospitals each month demonstrating errors in reporting.
6. For all infants referred from screening, identify all those with hearing loss by 3-4 months of age and begin intervention by 6 months of age.	1. Implement tracking system for hearing loss diagnosis by 3-4 months; 2. Complete resource guide for parents and CMS staff; 3. Provide education/counseling for all referrals. 4. Decrease age early intervention begins for hearing impaired infants; 5. Develop linkages with E.I. programs.	1. A tracking system in place; the average age of diagnosis is approximately 8 months during the reporting period. 2. A resource guide has been developed and distributed to 130 families. 3. 42 infants were referred to EI during FY99. 4. Agreements with E.I. programs and other links have been informal through FY99 but will be developed throughout FY00.

PM 11	**Performance Measure 11:** Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care **Healthy People 2000 Objective:** Objective 17.20 Capacity/ Infrastructure Building

Public Health Situation or Problem: Children lack access to health care because of finances, distance from services, lack of providers, and lack of enabling services.
Contributing Factors: Poverty, pre-existing conditions, lifetime caps on certain services
Significance: CSHCN are disproportionately low-income, and because of this, they are at higher risk for being uninsured. They are also more likely to incur more catastrophic expenses than healthier children. They are more likely to obtain health care of they are insured, this measure is an important indicator of access to care. Families often incur high out-of-pocket expenses for medical and non-medical support.

Measure and Status: Percent of CSHCN in state program with source of insurance for primary care, specialty care and enabling services.

	1997	**1998**	**1999**
Target	32	34	36
State Performance	32%	32%	57%

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators: 6/30/1999**
1. Calculate the number of and report on CSHCN in the CMS Program with available third party coverage– including insurance and Medicaid.	1.Calculate the number of CMS enrolled children with insurance and Medicaid. .	1. In FY99, the total with Medicaid, Indian Health Service or Insurance is 57% or 3,761 of 6,581 CMS children. This percentage has grown from the prior year likely due to the beginning of the CHIPS program that has increased the income level for Medicaid eligibility. Among the 2,617 Medicaid eligible there were ~ 305 children with IHS coverage. There were 1,144 with other insurance. (these categories may contain duplicates)

PM 12 **PM 13**	**Performance Measure 12**: Percent of Children with Health Insurance capacity/infrastructure **Performance Measure 13:** Percent of Medicaid eligible children enrolled in Medicaid Capacity/Process/Infrastructure

Public Health Situation: In 1998, New Mexico children under 18 had an uninsured rate of 17.1% down from 20.1% in 1997; national avg. is 15.4%. NM ranks 48th in the nation for children without health insurance.
Contributing Factors: Lack of knowledge of eligibility guidelines, barriers in language, attitude of ISD case workers, transportation, changes in PROGRESS (formally AFDC), Medicaid Managed Care.

Measure and Status:	**1995**	**1996**	**1997**	**1998**
State Target; % w/out insurance	75	74	80	80
Estimate, % w/out insurance	76	83		83
State Target, Medicaid enrolled	75	75	75	75
% Medicaid enrolled/qualify children	61	72		

Planned Achievements:7/1/98-6/30/99	**Activities**	**Progress on Indicators 6/30/99**
1. Policy and program initiatives through NM Child Health Insurance Initiative, to reduce No. s of uninsured	Family Health Bureau Chief/Title V Director serves as NM DOH designee on state-level planning group and provides guidance regarding effective policies and initiatives.	Title V leadership partnered with HSD Medical Assistance Division to provide guidance on effective outreach and eligibility policies.
2. Increase the percent of Medicaid eligible children to 75%	DOH entities to provide: 1. Clients with eligibility guidelines for MAC 2. Presumptive eligibility and MOSAA services; 3. Information on the Medicaid MCOs plans and provider networks; 4. Care coordination on Medicaid referrals; 5. Advocate for clients' on eligibility process.	1. 100% of children in Families First program are on Medicaid and belong to a managed care plan. 2. 3591 children receive care coordination.
3. Community-based activities incorporated w/Title V planning	The SSDI project shares State Title V performance measures planned achievements with CMCH Councils to identify local strategies	County MCH Councils successfully advocated for a simplified eligibility process
4. Increase % of children with mechanism of payment for primary services through HKF	Provide primary care under Healthier Kids Fund (HKF); Ensure coordinated access to HKF across all sector provider sites thru training and information for providers and communities	13,111 children served by HKF Enrollment frozen due in Jan. 1999 to budget constraints. Information shared with participating providers.
5. Monitor and produce reports of access, no insurance and related access problems	Develop capacity: use new family surveys of NM Health Policy Commission if appropriate; develop population based surveillance capacity for child health status and access to care if funding permits. Monitor existing data: Medicaid and census/poverty level data.	Sources for data on uninsured and insured continue to be explored as well as data about children using Medicaid. Medicaid eligible and number of children who can qualify for Medicaid.

PM 14	**Performance Measure 14:** The degree to which the State assures family participation in program and policy activities in the State CSHCN program **Healthy People 2000 Objective:** Objective 17.20 Process/Infrastructure Building

Public Health Situation or Problem: Families of CSHCN lack adequate information about programs, and the system of health care in the State. Health care services are typically not family-centered, and input from families may not be sought to improve the service delivery system. **Contributing Factors:** The service delivery system is fragmented and complex; a great number of CSHCN are now receiving their medical care through a Medicaid Managed Care model.	**Measure and Status:** State Target: 1996 na; 1997 na; 1998 12; 1999 13; 2000 14 State Performance: 1996 13; 1998 11; 1999 13 The scoring is 0-18 based on scoring in detailed performance measure description.
Significance: The last decade has emphasized the central role of families as advisors and participants in policy-making activities. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) created the legislative mandate that programs supported by Maternal and Child Health Bureau (MCHB) would provide and promote family-centered, community-based, coordinated care.	**Data Source:** The State CSHCN Program **Data Issues:** Whether the checklist is scored solely by the program or with the input of family members.

Planned Achievements 7/1/98 – 6/30/1999	Activities	Progress on Indicators 6/30/1999
1. Increased the participation of family members in the CSHCN program by 25 % as measured by the score.	1. Continue to work with Parents Reaching Out and Family Voices staff to obtain input in this scoring process. 2. Explore additional methods for increasing family participation.	1. Family involvement in the CSHCN program as scored by the characteristics outlined in the attachment. There were 2 characteristics which increased from the previous year included #3 Family members involved with MCH Block Grant process and #6 Family members of diverse cultures are involved in all of the above activities. Family participation in curriculum development for social worker training has been included for the first time.

Attachment-Performance Measure #14

SIX CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS

0 1 ***2*** 3* 1. Family members participate on advisory committees or task forces and are offered training, mentoring, and reimbursement, when appropriate.

0 1 ***2*** 3 2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

0 1 ***2*** 3 3. Family members are involved in the Children with Special Health Care Needs' elements of the MCH Block Grant Application process.

0 1 ***2*** 3 4. Family members are involved in inservice training of CSHCN staff and providers.

0 1 2 ***3*** 5. Family members are hired as paid staff or consultants to the State CSHCN program (a family member is hired for their expertise as a family member).

0 1 ***2*** 3 6. Family members of diverse cultures are involved in all of the above activities.

Total Score ***13***

*0-Not Met; 1-Partially Met; 2-Mostly Met; 3-Completely Met

Total the numbers in the boxes (possible 0-18) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

PM 15 **PM 17**	**Performance Measure 15 and 17-:** [15] Percent of very low birth weight live births, and [17] those born in tertiary care centersrisk factor Healthy People 2000 Objective: 14.15 Overall Goal: Reduce very low birth weight to no more than 1% of all live births. Risk Factor/Infrastructure

Public Health Situation or Problem: Premature infants bear an excess burden of developmental delay, costly medical problems: associated with risk behaviors.
Contributing Factors: Evidence suggests untreated bacterial vaginosis, destructive periodontal disease

Measure and Status	**1998**	**1994**	**1995**	**1996**	**1997**
VLBW %	1.11	1.03	1.14	1.01	1.07
VLBW #	306	277	303	271	293
Level III %	66.5(est)	66.7	70.8	75.2	66.4
Level III #	204	196	234	180	192 (est)

Planned Achievements:7/1/98-6/30/99	**Activities**	**Progress on Indicators 6/30/99**
1. Report analysis of trend for VLBW; NM shift upwards from <1% to 1.1%	Analysis by variables in Live birth file; discussion with perinatologists in tertiary centers to interpret findings; disseminate to appropriate groups	Not done due to inadequate staff
2. Report VLBW by PRAMS variables	Linked data, Live births and PRAMS, to assess VLBW; discussion with perinatologists in tertiary centers to interpret findings; disseminate to appropriate groups	To be finished by 12/2000
3. Strengthen state capacity to develop standards/interventions for perinatal issues related to violence, alcohol, substance use and tobacco.	Develop and implement training in use of VAST questions protocols for health care providers in PH offices, Title V contractors, MCOs, Families First.	Training developed and trainer in place
4. Increase the No. of pregnant women receiving education about risk factors that contribute to LBW.	1. Provide one to one teaching with F-FIRST clients in regards to nutrition, violence, alcohol, smoking and drug use during pregnancy 2. Provide educational materials 3. Referrals to appropriate resources	1. 2350 FF prenatal clients completed a prenatal educational session with materials 2. All FF clients identified with a VAST issue are referred if a community resource is available
5. Community-based activities will incorporated into State Title V Program planning to achieve performance objective	The SSDI project will share the State Title V performance measures and planned achievements with CMCH Councils to identify local strategies	County MCH Councils provided community based support for coordinating available resources and improve access to maternal and child health services

PM 16	**Performance Measure 16:** The rate of suicide deaths among youths aged 15-19 **Healthy People 2000 Objective:** Related to 6.1 and 7.2a Reduce suicides to no more than 8.2 per 100,000 youths aged 15-19. Risk Factor/Infrastructure Building
Significance: Suicide is the 8th leading cause of death in the US. Among youths aged 15-19 it is the second leading cause of death and has been increasing steadily since the 1950's.	**Measure and Status:** The rate of suicide deaths to youths aged 15-19. The 1997 rate was 13.8 for youths aged 15-19.

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Develop a suicide prevention network in each health district.	1. Include as part of overall youth development strategies information on suicide issues to communities and schools. 2. Sponsor a Youth Suicide Prevention Awareness Symposium in each of the health districts.	11 communities and schools have rec'd training District 2 and 4 have had full workshop. 8 youth and 34 adults were trained on the impact of suicide. Other training was postponed due to the vacancy of the Public Health Educator. Activities will resume when position is filled.
2. Develop a mental health referral/service system in each school based health center (SBHC)	1. Work with the Mental Health in the Schools Initiative to set up a clear referral pattern and mental health infrastructure for each of four pilot sites. Include this group as statewide suicide plan moves forward.	Legislation passed based on recommendations of initiative's workgroups. District Mental Health advocates trained in suicide prevention issues.
3. Monitor suicide/ non-fatal data	In collaboration with UNM, DOH epidemiology and injury control, establish a county wide pilot surveillance system	Surveillance system established in at least one county. 63 case files of 1997 suicide deaths in 10-24 age group reviewed; only 26 families could located to provide interviews. See the CFR Report for findings on suicide trends and recommendations for prevention/intervention strategies. Access to firearms in the home had significant relationship to suicide deaths.
4. Community-based activities will be incorporated into State Title V Program planning to achieve performance objective	The SSDI project will share the State Title V performance measures and planned achievements with CMCH Councils to identify local strategies.	MCH Councils actively involved in suicide prevention

PM 18	**Performance Measure 18:** Percent of infants born to pregnant women receiving prenatal care in the first trimester Healthy People 2000 Objective: 14.11 Increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. Risk Factor/Infrastructure Building

Significance: In 1997, 66.8% of women enter prenatal care during 1st trimester.

Contributing Factors: lack of knowledge regarding importance of early PNC; July 1, 1997 the beginning of NM's Medicaid Managed Care and the added enrollment process after Medicaid approval, transportation problems in large counties; lack of PNC providers in rural areas; denial of pregnancy; younger mothers

Measure and Status:

	1991	1992	1993	1994	1995	1996	1997	1998
High level care	44.1	46.5	48.6	50.9	52.6	52.7	52.7	63.8
Medium level care	37.2	35.4	35.8	34.5	30.5	30.6	30.4	
Low/No level care	15.3	14.3	12.6	10.9	11.7	11.8	11.1	
1st trimester care	56.7	58.4	62.3	64.9	66.9	67.1	66.8	

Numerator: No. of women identified by level of PNC
Dominator: No. of births in NM

Planned Achievements 7/1/98 – 6/30/1999	Activities	Progress on Indicators 6/30/1999
NM Families First: 1. Increase 1st Trimester Prenatal care levels to 70%.	1. Development of a statewide FF network to provide case management to the three MCO Salud members. 2. Provide Presumptive Eligibility and MOSSA for eligible pregnant to decrease waiting time for 1st PNC appointment.	1. As of 6/99, FF has 53 providers in 31 out of 33 counties in NM. 2. 80% of FF clients received PE and MOSSA services.
NM Families First: 2. Ensure uniformity of statewide Families FIRST services	1. Credential new providers 2. Orientate new providers to FF model 3. Train new providers to FF model 4. Require attendance at FF mtgs. 4. Perform yearly quality assurance reviews on all providers 5. Incorporate VAST curriculum into interview techniques.	1. 58 new sites approved and credentialed to provide FF services 2. Conducted (6) two-day trainings to orient new case managers 3. All providers that attended a training received an on site orientation visit. 4. 90% of the FF providers attended the required # of meetings 5. All FF providers had a yearly quality assurance review with an audit of 30 charts per case manager 6. 75% of the FF case managers were trained in VAST
NM Families First: 3. Monitor quality improvement for pregnant women and infants who receive case management services.	1. Monitor service indicators: avg. caseload 150-200/FTE 2. Analysis Families FIRST evaluation data for 1997.	1. FF served 3133 women and 3591 children for a total of 6724 served for FY 99 2. Unable to produce this evaluation data do to changes in the Divisions computer system.
Maternal Health Program: 4. Ensure financial access to prenatal care by use of the High Risk Prenatal Care fund	1. Collect and analyze data re use of fund. 2. Refine eligibility categories to best prevent poor pregnancy outcomes.	1. Approximately 460 high-risk pregnant women served. Began development of Fund usage database. 2. Eligibility categories reviewed and updated.

		Pre-authorization for unusual cases remains option.
Maternal Health Program: 5. Support statewide prenatal care contracts to meet identified gaps in care.	Regular contact with prenatal care providers through site visits/phone conversations.	No site visits. TA given by telephone to each provider as needed.
Maternal Health Program: 6. Ensure that public health clinics offering prenatal care receive essential technical assistance and support.	1. Revise prenatal protocols as needed. 2. Visit and/or regularly contact by telephone PH clinics. 3. Provide technical assistance on new or old procedures as needed. 4. Encourage continuing education on prenatal issues by clinic personnel.	1. Prenatal protocols revised and updated. 2 . Each PH clinic offering prenatal care contacted many times for TA and updates by telephone and by memo. 3. Clinical prenatal issues discussed at quarterly clinician meetings.
Maternal Health Program: 7. Promote training, recruitment, and placement of mid-level providers in prenatal care settings (CNM, LM, CNP, nutritionists, social workers, etc)	1. Increase no. of CNMs practicing in NM, and their geographic spread. 2. Encourage independent hospital privileges for CNMs. 3. Increase no. of LMS practicing in New Mexico.	1. 4 new CNM services started in under served locations. 2. CNMs have independent hospital privileges in one NM IHS hospital. Committee work done with Hospital credentialing agency toward changing hospital regulations to allow hospitals to grant medical staff membership, independent privileges and admissions for CNMs and other licensed independent practitioners, + medical staff membership and limited privileges for allied health personnel. 3. Births by LMs remains approximately 0.8%.

SP 19	**Performance Measure 19:** To increase the number of counties adopting the conceptual framework of Health Youth/Healthy Communities through an Assets/Resiliency model approach when working with youth. Healthy People 2000 Objective: none

Significance: Research indicates youth report a lack of building blocks or developmental assets necessary to grow up healthy, competent, and caring. **Contributing Factors:** Federal, state, local governments, communities, schools, and families commonly address issues by naming problems (violence, suicide, pregnancy) and try to reduce incidents rather than building on assets/resiliency or protective factors that nuture the core experiences needed to be healthy.	**Measures and Status:** **1999:** 36% of counties (12/33 counties) have adopted the Assets model. By the year 2000, increase the number of counties adopting the model by 6% or 2 more counties. **1999:** 30,730 students have completed the survey Search Institute Profiles of Student Life, Attitudes, and Behavior which reports individual assets. By 2000, increase the number of completed surveys by 25% or 7682.

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Enhance the development of the YAC assisting the FHB in the planning, implementation, and evaluation of this initiative.	1. Contract with 2 youth as partners for a minimum of 2days/week to strategize, design, and evaluate youth programs within the FHB. 2. Recruit 16 youth, ages 12-24, to participate on the YAC. 3. Hold 4 quarterly meetings to train youth and share information. 4. Expand YAC outreach to include a minimum of 2 presentations in local communities. 5. YAC partner on issue such as tobacco, teen suicide, violence prevention, and abstinence only programs. 6. Assist with 3 trainings throughout the year.	Two youth contracted to coordinate council but one resigned mid way through contract; 14 members recruited for council with 5 new youth participating. Three formal trainings held during 1998/1999 school year. Formal trainings reduced to 3 to allow for more funding of council representation at the state and local level. 15 meetings attended by YAC concerning issues of tobacco, suicide, and abstinence. 8 trainings given technical assistance by YAC to schools, public health staff and non-profits.
2. Four new counties will adopt the Healthy Youth/Communities through the Assets Building Initiative.	1. Provide health districts with training on Asset/Resiliency model of Youth Development. 2. Provide 4 MCH county councils with same training. 3. Develop a system to distribute A/R materials in each health district. 4. Provide TA and resources to develop a marketing campaign on A/R model. 5. Provide TA to administer the Search Institute Profile Survey.	3 trainings offered to Public Health Districts 8-10 council members participated in youth coordinated trainings including offering training tract at MCH Council Institute attended by 24 county councils.; Program has purchased educational materials valued at $3,000; materials have been distributed at statewide conferences and local communities. Increase from 8 to 12 the counties collecting baseline data on youth assets.; Increase of 6030 students completing Search Profiles of Student Life, Attitudes and Behavior surveys and analysis for 11 school districts was $26,000 of MCH Block grant.

SP 20	**Performance Measure SP 20:** Proportion of first newborns/mom receiving support services/ parenting education through community homevisiting/support programs. Healthy People 2000 7.4: Reverse incidence of maltreatment of children less then 18 (includes physical, sexual and emotional abuse/neglect.) Enabling/population based

Public Health Situation or Problem: increasing challenges of parenting and providing stable families. **Contributing factors:** Changes in family structure such as increasing numbers of teen and single parents, young parents not prepared to parent their children, divorce rate, children spending less time with their parents, more children living in foster care, exposure to violence through the media, number of children living in poverty andnew scientific research on stimulating brain development in infants.	**Measure and Status:** 1. 9.3% of first time mothers checked "Home Visiting" on the PRAMS list of services used prenatal 2. 16.7% of first time mothers checked "Home Visiting" on the PRAMS list of services used postnatal, 0-2 months

Planned Achievements 7/1/98-6/30/99	**Activities**	**Progress on Indicators 6/30/99:**
1. Participate in the establishment of a statewide infrastructure in collaboration with other agencies (public and private that will support the development of community home visiting/ parenting education programs	1. Continue collaboration with agencies to implement the FS/FP Plan: 3rd party payment, curriculum development and training; 2. Provide TA/ training on Keys to Caregiving, PCI, and research on stimulating brain development in infants; 3. Provide TA relating to home visitors and program management; 4. Collaborate with Families FIRST to assure that HV is an part of infancy. 5. Promote public awareness relating to new scientific research and value of HV/family support.	1. 25 training workshops were offered to FS/FP sites. 3 sites will be included in final evaluation of training. 2. 11 classes in Keys to Caregiving and 15 workshops on home visiting related topics 3. 18 TA contacts 4. 2350 FF infants received at least one home visit. 5. “From Day One Baby Knows” marketing campaign evaluation indicated that parents are eager to receive information about babies and wanted simple messages about parenting
2. Community based activities will be incorporated into State Title V Program planning to achieve performance objective	The SSDI Project will share the State Title V Performance Measures and plans with CMCH Councils to identify local strategies	Home Visiting is a funded priority in 8 County MCH Plans
3. Increase access to home visiting/parenting education prenatally.	Development of a 3-yr. pilot project that provides a continuum of services starting prenatal to include care coordination, home visiting and parenting education.	FF care coordination for pregnant women enrolled in Medicaid and their infants expanded to include 2350 families who received a home visit

SP 21	**Performance Measure 21:** Reduce unintended pregnancy in New Mexico Healthy People 2000 Objective: Reduce to no more than 30% the proportion of all pregnancies that are unintended

Significance: Unintended pregnancy [mistimed or unwanted] is associated with low birth weight, infant mortality, maternal health risk behaviors, low use of preventive health services by mothers and their infants. There is a need to promote planned and healthy pregnancies across all age groups and genders in New Mexico. **Contributing Factors:** include inadequate access to affordable Family Planning services; a need to better inform and educate regarding preconceptional health in women and men; lack of male involvement in sexual responsibility and family planning; lack of FP and PCPs who conduct a thorough assessment of preconceptional health	**Measure and Status:** Access to and use of FP services will be produced in **1998** Unintended pregnancy: not available will be produced in **1998** **Data Sources:** Clients served from Medicaid billing files and Public Health Division service reports; if pregnancy is intentional will come from NM PRAMS and NM BRFSS

Planned Achievements: 7/1/98 – 6/30/99	**Activities**	**Progress on Indicators 6/30/99**
1. To address the needs of low-income women, adolescents, and persons at high risk of STDs by providing education, referrals, and specialized outreach.	17 FP sites will provide education, outreach, and referrals to high-risk clients through cooperative arrangements with other community programs and agencies. The State Office will continue to: support District requests for increase of PA's when appropriate; support local health office initiatives for integration of clinical services; promote efforts of local and district offices to utilize mobile van for outreach initiatives/integrating clinical services to include FP.	Total of organizations: 290 Total presentations: 189 Total clients reached: 4240 Total referrals made: 2713 Topics: STD, pregnancy; life choices, career, resources, relationships, male involvement Outreach: newspaper, radio, public postings, local organizations, Teen-Zine magazine. Total PA's: 16; One PA site cancelled due to district request, one new PA initiated. State office is implementing an integrated management information system (IMIS) for PHD program integration. WIC/FP mobile vans continue. All appropriate referrals from WIC to FP are completed. Condoms available to WIC clients.
2. Improve clinical access through expansion of existing hours, development of new clinic sites, and increased staffing as funding is provided.	Increase Nurse Practitioners who are trained to provide reproductive health services	2 Nurses were trained.
3. To improve clinical access for clients.	Family Planning sites will develop and provide accessible programs through integration of clinical services and utilization of the Quickstart waiver.	Sites utilizing QUICKSTART: 38 Sites providing integrated serv.: 39 such as STD 35, Immunization 32,

		WIC 32, Breast and Cerv Cancer 31, HIV 25, Other 25.
4. To provide contractual staff	Pending funding availability, one FP site will expand clinic hours to include evening and Saturday services; specialized OB/GYN services in unserved areas To provide funding for contractual staff to provide specialized OB/GYN services in areas where such service is not otherwise available	7 Family Planning staff contracts, 1 additional FTE to Family Planning/Integrated provider staff. 137 evening or Saturday clinics. 5 contractors providing OB/GYN .
5. To increase community awareness	4 FP sites will increase awareness of the population at high risk of unintended pregnancy through selected media	4917 flyers, 38 newspaper articles, 197 posters distributed and 41 PSAs
6. To network with other state programs on media outreach	Continue a statewide media campaign sponsored by MCH and Human Services Department.	Materials distributed: "Not Yet" magazines: 10,000 "Man To Man" video: 150 FP Information cards: 3,700 FP Posters: 115 Sp/150 Eng = 265
7. To address cultural diversity	State Office will support, through various means, family planning providers to address the specialized needs of diverse cultures State Office will provide training to family planning providers to address cultural diversity.	Activities: medical interpreters, Health Ed in Spanish, bilingual staff, and health fair booth, individual appointments for services, posters and health education materials, cross cultural training, department supported several staff members taking Spanish classes, outreach to School for the Deaf and Indian School, guest lecture to non-traditional student population, Project Respect, "Day in the Park", outreach to incarcerated teens. 0 people attended a presentation on cultural diversity during Teen Pregnancy Prevention teleconference.
8. To increase availability of family planning methods to the community	3 local site's and the State Office will make condoms more available to the community through innovative techniques; Support appropriate expansion requests for PA's and focus on implementing 1115 Medicaid waiver.	Condoms distributed: 397,300. Methods to distribute: 40 brown bag specials, 12 condom campaigns, 30 basket at front desk, 17 during presentations, 27 health fairs, 10 street outreach, 15 other. Provider Agreement expansion requests: 2 The New Mexico 1115 Waiver is in

		process of implementation
9. To improve community health planning	Will continue to collaborate with MCH Councils regarding community health planning State Office will support community planning activities at the community level	223 collaborative meetings were held with MCH Councils. Meeting Outcomes include: community surveys, case management and abstinence outreach, collaboration with 1115 Waiver planning, collaboration with SBCs, prenatal/postpartum visits, additional MCH councils, teen parenting services, activities to promote youth development, self esteem, youth mental health services networks, youth fairs, "Teen Town Hall," Violence Prevention, transportation services, car seat program, health and wellness fairs, schools preschool screening. There are 24 MCH County Councils working with the State Family Health Bureau.
10. To increase clinic access	At least 4 clinics per district will perform a PFA to evaluate efficiency of clinic services. At least 4 clinics per district will increase clinic access based on PFA results Nurse liaison will follow up with Directors of Nursing Service to help analyze results of PFAs and develop further training as needed.	17 Patient Flow Analyses done: 13 sites report changes such as: adjusted schedules, circulating nurse, expanded hours, increased 'walk in' appt., All Department of Health sites are working on improving integrated clinical services. 1 district conducts monthly clinical services eval meetings through 6/99, with a consultant provided by the Family Planning Program. This pilot clinic management project that may be replicated statewide. The results are presented at bi-monthly meetings of all Directors of Nursing Services. Highlights are presented at annual Clinic Management workshops.
11. To enhance staff knowledge about preconception initiative	Based on funding available, State office will provide staff training to local office staff regarding behavior change to	No specialized funding was available for staff training. Standardized

	improve preconceptual health, and administration of risk appraisal tool.	Universal Health History intake assessment tool instituted in health offices. Assessments are applicable to preconceptual health.
12. To pilot revised self-appraisal tool	Pilot revised tool.	This initiative is no longer with DOH.
13. To obtain additional funding for expansion of Preconception Counseling Project	To collaborate with DOH and 1115 waiver initiative	Same as above
14. To expand number of sites offering Preconception counseling	Increase preconception counseling sites	Same as above
15. To provide guidelines for local client referral, and standardized educational materials	Based on funding, state office staff will provide ed materials and utilize community sources for referral.	Same as above
16. To disseminate sexuality information and increase awareness.	22 FP clinic sites will network with schools, community organizations, and parent groups to present age appropriate education (i.e. materials, technical assistance). State office health educator will participate in meetings to identify needs/resources.	347 presentations Meetings attended: 25 Needs identified: continue collaborative efforts
17. To integrate family planning education into alternative settings.	At least 4 family planning clinic sites will provide family planning counseling and education to teens in other non-family planning settings (TWIC, WIC, and STD). State office will assess multi-media software.	35 sites provide Family Planning counseling and education in non-family planning settings.
18. To analyze collected survey data	State office will analyze community surveys assessing family communication re: human sexuality	Focus groups were conducted in 1115 Waiver research component.
19. To increase male awareness regarding sexual responsibility	The male involvement component of the Family Planning Program will continue to support male involvement activities in the community through contracts, MOA's, and educational materials.	Contracts and MOAs: 10 Materials distributed: Pamphlets 15,000 Videos 160
20. To participate in the "Not Yet" Campaign.	FP State Office will collaborate with other DOH programs to develop and disseminate the next phase of the "Not Yet" media campaign.	"Not Yet" Campaign is over. "Not Yet" magazines: 10,000 "Man To Man" video: 150
21. Community-based activities incorporated into Title V Program Planning to achieve performance objective.	The SSDI Project will share the State Title V performance measures and planned achievements with CMCH Councils to identify local strategies.	County MCH councils provided support for the 1115 FP Waiver

SP 22	**Performance Measure 22:** Reduce the number of children exposed to domestic violence or sexual violence. Healthy People 2000: 7.5 Reduce physical abuse directed at women by male partners to no more than 27/1000 couples. 7.7 Reduce rape and attempted rape of women aged 12 and older to no more than 10/1000. 7.4b Reverse to less than 2.5/1000 children the rising incidence of sexual abuse of children younger than age 18.

Public Health Situation: Many children and young adults are exposed to domestic violence in the home or experience some form of sexual violence from people they know. Adverse effects include substance abuse, teen pregnancy, truancy, eating disorders, suicide, aggressive and sexual acting out, and school failure. **Contributing Factors:** Lack of mental health infrastructure to cope with exposures. High prevalence of domestic violence. Lack of protective skills in avoiding acquaintance rape.	**Measures and Status:** Rate of domestic violence, rape, and sexual abuse. **1997:** NM Child Sexual Abuse rate was 1.2/1000, 1997 NM Rape rate was 52.8/100,000 (UCR Data). No accurate measure of DV available.

Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Expand the number of people actively working to end domestic violence and who understand the adverse impact on children who witness violence.	1. Continue to strengthen the Domestic Violence Advisory Group, needed legislation, and an agreed upon definition of the domestic violence rate in the state. 2. Hospital trainings to occur statewide 3. Create a pilot site where children witnessing domestic violence are referred to social services and a collaborative approach occurs in response.	VAST trainings are formulated and protocols developed. Over 1000 people statewide are trained in basic information about domestic violence. Initial trainings are done in each region. Pilot site not established. Two different groups are working on the specific issue of children who witness violence.
2. Support community based initiatives	Continue creation of local teams	Existence of DV teams in 28 towns/cities.
3. Expand education in schools on date rape and child sexual abuse awareness.	Continue education on good touch/bad touch/secret touch through community-based coalitions and local rape crisis centers.	Over 1000 students and 200 parents are trained. Collaborative advisory committee is being reformulated.
4. Continue expansion of coordinated hospital based model of caring for rape victims (SANE)	Expand to one site beyond Albuquerque	New site added in eastern New Mexico
5. Increase the number of local providers trained in the diagnosis/treatment/and mental health referral for sexually abused children.	Expand the UNM Para Los Ninos Sexual Assault program to rural New Mexico.	Most PCPs statewide are aware of available consultation.

SP 23	**Performance Measure 23:** Implement PRAMS and use data for policy and programs Healthy People: relates to assessment objectives Capacity/Infrastructure

Public Health Significance: need for data to better understand multiple issues: access to and use of prenatal care and related health services, maternal and partner risk behaviors, social determinants of health behaviors and selected birth outcomes,	**Measure and Status:** Target: implement PRAMS by FY1998 State performance: PRAMS now into ongoing operations and data analysis July 1997

Planned Achievements: 7/1/1998-6/30/1999	**Activities**	**Progress on Indicators: 6/30/1999**
1. NM PRAMS data collection achieves 70% response overall	1. Monitor responses each batch; overall within strata; 2. Evaluate monthly incentive response and adjust according to findings 3. Assess border county performance and consider community contract protocol.	Evaluation of response problems carried out; new issues identified and evaluated; response levels increase with suitable interventions.
2. NM PRAMS questionnaire and materials revised for FY 2000	1. Cognitive testing for FY 2000 core 2. State based questions conducted and language level of letters ascertained	Questionnaire and materials are ready for FY2000 birth file samples.
3. Produce 1997-99 NM PRAMS data for use in comprehensive needs assessment and publish surveillance report.	1. Target depends on NM Vital Records, timely submission of 1998 birth files to CDC PRAMS and weighting 2. Complete NM + CDC procedures for weighting of 1998 birth cohort data set. 3. Analysis of data with specific focus on performance measures.	Submission of birth files by 7/15/99 and return of weighted file from CDC by 10/15/99 Analysis of data for all performance measures and health status indicators by 3/30/2000 Data used in Title V prioritization and planning process.
4. Provide data analysis on high priority areas	1. Expect continued data 2. Analysis on intended pregnancy, breastfeeding, and home visiting to fulfill performance measure analysis	Special analysis projects completed and disseminated to community partners Used for program planning, client and provider education and policy decisions.
5. Maintain high level involvement of Steering Committee and funding partners	1. Three steering committee meetings per year 2. Prompt reporting to funders 3. Recruitment of additional partners to support NM PRAMS	Meetings held Funding of PRAMS continues at acceptable levels.

SP 24	**Performance Measure 24:** The state has a coordinated program of maternal, fetal, infant and child death review

Public Health Situation or Problem: Vital Records reports provide mortality data by age, gender, Ecode and diagnosis, geo residence. They do not give insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. Death review methods provide this; NM mortality rates for intentional and unintentional injuries are high.	**Measures and Status:** **1998** **1999** **2000** **State Target** 3/3 2/3 3/3 **State Performance** 2/3 MMR/FIMR/CFR Operational = 3/3

Planned Achievements: 7/1/1998-6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. MMR and CFR teams, including NEO, are fully supported and produce annual reports	1. Refine MMR and CFR functions 2. MMR: set up data base, enter all cases 1996-present 3. Reports: MMR: produce report by Dec 1999 CFR: all 6 special panels fully functioning CFR: data base set up; all cases entered CFR: produce report by Dec 1999	MMR and CFR: teams fully functioning MMR and CFR: combined report published by Dec 1999 MMR and CFR: data used for comprehensive MCH assessment MMR: data presented at national MICHEP meeting
2. Detailed 10 yr. trend analysis for fetal, infant, child mortality data produced	1. Obtain missing linked data from vital records [1997 and 1998]; analyze data; produce report 2. Obtain fetal death files, only if possible due to constraints of NM Vital Records in 1999-2000 period [retooling system] 3. Assess FIMR data for NM FIMR team	1. Data request in Oct 1998; data received Jan 1999 with 8 years linked birth-death data; First analysis by cause of death in neonatal-postneonatal period produced; complete analysis with SES indicators to be complete Dec 1999.
3. Detailed analysis of data for performance outcome and assessment/health measures produced.	1. Detailed analysis produced re MV Crash, age 1-14; teen suicide, infant, neonatal, postneonatal, perinatal mortality; child mortality age 1-14; and other data analysis related to the comprehensive assessment.	Data produced for use in community outreach in 4 districts for planning by August 1999; and for use in prioritization and planning by March 2000
4. MCH death review staff and support staffing needs met	Funding support continues for Epidemiologist-coordinator and 0.5 FTE support person	Staff continues uninterrupted
5. One community-based review process developed	Las Cruces, with US Mexico border health office and district III epidemiologist, set up team, train and conduct reviews, and produce information for prevention.	Las Cruces community based review team development continues; data and information lead to prevention strategies

SP 25	**Performance Measure 25:** To identify children born with birth defects and reduce the incident of neural tube defects. Capacity/population based	
Significance: The financial, educational, and social costs accompanying birth defects, especially neural tube defects (NTDs) are very high.		**Measures and Status:** Actual rates of birth defects including NTDs. Numerator: Number of children identified with NTDs and other selected birth defects. Denominator: Number of live births.
Planned Achievements 7/1/98 – 6/30/1999	**Activities**	**Progress on Indicators 6/30/1999**
1. Complete annual report for 1997 and 1998 birth defects including NTDs.	1. Complete linkage of birth defects registry to live birth file and children's chronic conditions registry for 1997 and 1998 births. 2. Complete epidemiological analysis for established rates.	1. Number of linked records. 2. Completion of report.
2. Complete occurrence and recurrence prevention activities as identified in grant from CDC through Birth Defects Prevention and Surveillance System.	1. Complete identified occurrence prevention activities and evaluation. 2. Complete recurrence prevention activities including referrals and educational and genetic counseling for affected families.	1. Evaluation of occurrence prevention outcomes (including data from surveillance system). 2. Number of families referred for education/counseling and number actually receiving it. 3. Evaluation of recurrence process.
3. Complete surveillance of birth defects including NTDs.	Evaluation of efficiency of system including rapid ascertainment of NTDs.	Comparison of New Mexico rates to other similar systems.

2. 5 Progress on Outcome Measures

The information provided here is the same as our report and application of last year, which is inclusive of 1997 data. The NM VRHS is in process of re-engineering their system and not able to provide 1998 data in time for this report. More details will be found in the comprehensive assessment. Figure 2b denotes New Mexico based services. Performance Measures 8 and 18 were dropped. PM 8 changed to State Measure 24 for the grant.

Figure 2A

CORE PUBLIC HEALTH SERVICES

DELIVERED BY MCH AGENCIES

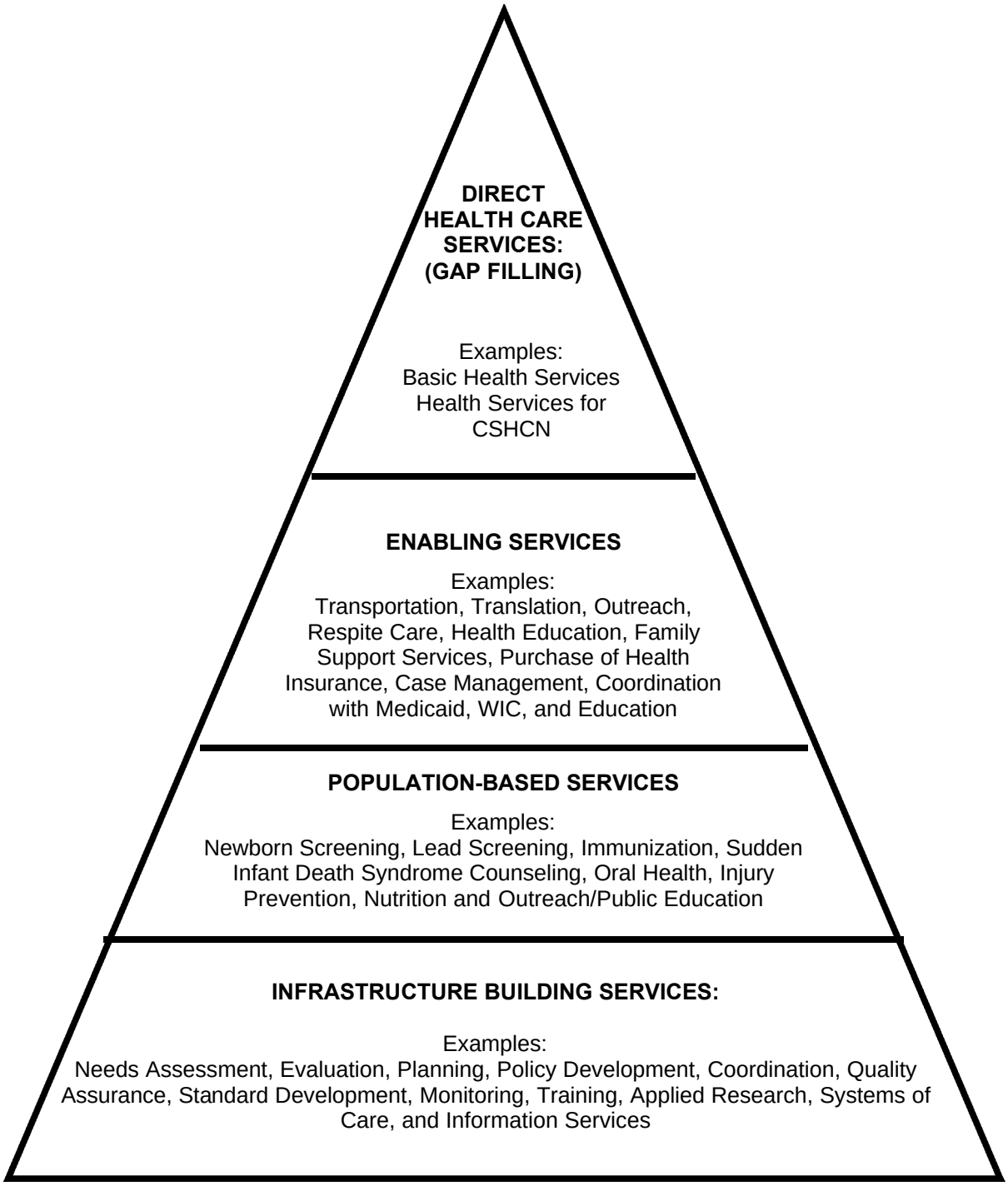
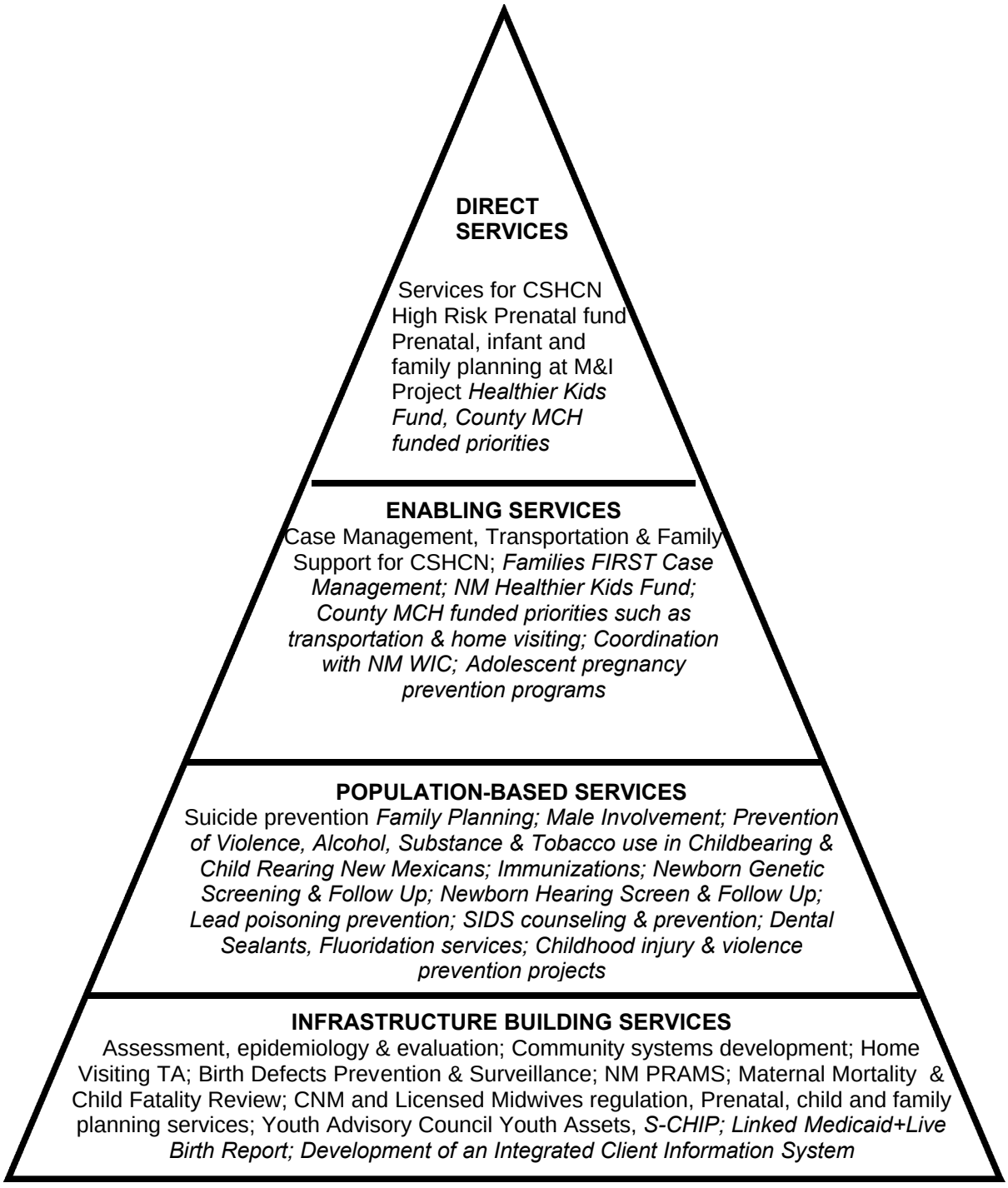


Figure 2B
CORE PUBLIC HEALTH SERVICES
DELIVERED BY NEW MEXICO MCH AGENCIES

Note: Programs that are carried out in partnership with the Title V MCH program are italicized; Programs that are fully implemented by Title V MCH resources are in plain type.



III REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.3 Needs Assessment Process

Community Involvement: The Family Health Bureau's (FHB) Chief, Medical Director and Program Managers for MCH, Maternal Health, Adolescent Health and Youth Development, Children's Medical Services, Women Infant and Children's Supplemental Food, Dental, Families FIRST, Family Planning, MCH Epidemiology traveled to the four Public Health Division Health Districts to conduct an MCH needs assessment workshop. The District Management Team along with selected MCH partners such as HeadStart, MCH County Councils, and Indian Health Services (I.H.S), participated in the session. The FHB team used a Powerpoint™ presentation to share information about Title V MCH Block Grant, the pyramid, data and the conceptual framework for assessing each of 4 population groups:

1) Reproductive age women,
2) Children age 0-3;
3) Children age 4-9; and
4) Preteens, teens and youth age 10-24.

Each District Director presented information about needs of the MCH population and the present processes for conducting needs assessment, planning and evaluation. The agenda, slides of the Powerpoint™ presentation, full text of the results of the work group sessions for each district, and the participant lists are available upon request. At each district, the tasks of the workshops were:

1. The District team will be oriented to the assessment in order to effectively address health needs of the MCH population in New Mexico and as required by Title V Block Grant.
2. The Family Health Bureau (FHB) will be oriented to the District III planning process and MCH priorities.
3. All participants be oriented to, explore and possibly strengthen a conceptual model for population based assessment, with domains of assessment
4. The District team will contribute to FHB's understanding of key issues and contributing factors effecting health outcomes for each population group. The emphasis will be on District specific data, observations, information and experience
5. FHB and District teams will share information about any assessment work including evaluation and epidemiology

The morning session was used to describe the Title V MCH program at the national and state level, to examine trends in selected data, and to present the domains of assessment of the population groups. Each group was then asked to provide information for these questions:

1. Review the population-based model: Are there additional domains for assessment that need to be addressed?
2. For this population, look at the domains of assessment: what are the District or local community concerns we need to be aware of?

3. Think of priority health problems, health service gaps, health system strengths or constraints, weaknesses in the service system
4. At the District or local community level, do you have data or information that you use now for focusing policies, strategies, interventions or initiatives?
Cite use of existing data from other sources. Cite any special studies or research projects that have been done at the District or local community level
5. What kind of data or information does the district need but doesn't have to develop effective policies, strategies, interventions or initiatives?
6. What can you tell us from the District or local community experience about what works? Model programs or initiatives? Best practices for dissemination of data and information?

Data Base Specific Information: The need for quality data to monitor status and evaluate programs continues to be expressed at all levels from the State Legislature to local Maternal and Child Health (MCH) councils. In the past 2-4 years, several key systems have featured upgrades, re-engineering or entirely new data systems. Specific notes are included about these databases and their use in the assessment:

Re-Engineering at New Mexico Vital Records: The NM Vital Records system was re-engineered to coincide with the shift to Year 2000; this was achieved without significant funding or extra personnel. The upgrade involved new hardware and software, a transition from the mainframe to the PC environment, and new coding for files. The ICD-10 went into effect, also requiring intensive training and data adjustments. During this time the lead MCH data analyst and the VRHS Epidemiology group's manager left and were replaced in Fall of 1999. Ongoing VRHS functions continued in spite of low staffing including support to NM PRAMS. Special projects such as the linked Medicaid Birth analysis were put on hold; the latter report for 1997 births will come out in Fall 2000.

Population Denominators at NM Vital Records All of the mortality and natality rates published by VRHS were revised in Spring 2000. According to VRHS, the revised population estimates are derived from taking the 1990 modified (but unpublished) census counts from the Census Bureau received through BBER/UNM and the 1998 unpublished estimates (10/99) from BBER and deriving estimates for the intervening years. BBER uses certain data apparently not considered in estimates from the Census bureau (such as in-migration and other factors - census projections have Albuquerque and Bernalillo county declining in population!). In addition the Census bureau is constantly updating its population figures but does not publish these updates. BBER works as a partner to the Census Bureau as part of the Federal-State Cooperative Program for Population Estimates. Apparently the Census comes up with a national population figure and then apportions it to the states. Each intercensal year new population estimates are published that include preliminary estimates for the most recent year and revised estimates for previous years. These are called "vintages." The estimates are calculated using a "components of change" model that includes births, deaths, and migration. Each year there is new information, so the estimates for previous years are revised. Since there is more information we use the latest available vintage since this is probably closer to the "true" population number. The rates for census years are considered the most "accurate" (if you don't consider the undercount issue) because they are based on the census counts rather than estimates. Rates for census years are most trustworthy. Ideally, when a new census is done, then rates should be recalculated for the previous decade. The National Center for Health Statistics does this, although they are about 40 years behind :-). If it is still during the intercensal period then rates should be recalculated with the newest estimates.

Finally New Mexico was one of the most undercounted states in 1990 - this is why we prefer to use BBER estimates rather than the official published Census figures. We are hoping that the 2000 Census is a more realistic count.[28]

Child Abuse and Neglect: The Protective Services Division of the Children, Youth and Families Department (CYFD) developed FACTS, a new electronic data system for managing case documentation of child abuse and neglect. This system was three years in development (1997-1999). Data for the year 2000 is considered to be good; data for previous years has some problems associated with implementing a statewide data system such that trend analysis cannot be attempted. Data for 1999 did not report substantiated cases by age, race, ethnicity and gender; nor did it did report for alleged victims (substantiated and unsubstantiated). In fact, data reported to Title V MCH Block grant in previous years was for substantiated and unsubstantiated totals (alleged victims). As with many agencies, this new data system will permit more accurate assessment; previous data should be used with informed caution.

Evaluation of Transition Services for Youth with Special Health Care Needs: Children's Medical Services and the Adolescent Health and Youth Development Program contracted with Sandra Vail, a parent of a special needs child, for this evaluation. To cover the five different areas detailed below, the researcher did literature searches and interviews with key informants, and set up a series of focus group discussions with youth in transition. To investigate the transition-related services offered by New Mexico state agencies, commissions, and organizations, the researcher conducted literature research and interviewed the indicated representatives of the following agencies/organizations:

Department of Health (DOH)
Adolescent Transition Group: Marie Di-Bianco Eik, Adolescent Transition Group
Behavioral Health Services Division: Nancy Mechawk and Marie De-Bianco Eik
Long Term Services Division: Jennifer Brown, Developmentally Disabled Waiver Program; Marilyn Price, Deputy Director; Marilyn Pearson, Medically Fragile Waiver Program; and Brooks Levendoski, Traumatic Brain Injury Program Manager
New Mexico State Hospital in Las Vegas: David Brachilarge, head of the CARE unit and leader of the Sex Offender's Round Table

Children Youth and Families Department (CYFD)
Child Protective Services: Carlotta Garcia, social work supervisor; Joe Shivers, Northern New Mexico Regional Independent Living Coordinator; and Kirk Rowe.
Juvenile Justice, Probation, and Parole: Cynthia Leyba, Policies and Procedures, and Dr. Dale Bolson, Superintendent for Education
Prevention and Intervention: Linda Davis, Office of Managed Care and Adolescent Transition Group

Department of Education and Local School District Programs
Department of Education, Division of Vocational Rehabilitation: Richard Jiron, Statewide Transition Coordinator; Andy Winnegar, Technical Assistance Program Coordinator; Kelly Davis, Project SUCCEED Program Manager; and Pat Putnam, Transition into Apprenticeship Manager
Department of Education, Special Education Unit: Carol Brito, Transition Coordinator
Albuquerque Public Schools: Marilyn D'Ottavio, Transition Services Coordinator
Roswell Independent School District: Linda Nokes, Transition Coordinator

Department of Labor:
Rachel Sayre, Workforce Investment Act, and J. Howard Deme, Albuquerque office

Programs and Schools for Juvenile Offenders
New Mexico Boys' School: Martin Bochenek, head of the EQUIP program
Youth Diagnostic and Development Center: Cynthia Mims, Sandia Sex Offender's Program

Programs and Schools for Children with Special Needs
Commission for the Blind: Gail Melpolder, STEP program coordinator; Vicki Chapman, Transition Chief; and Victoria Vigil
Commission for the Deaf and Hard of Hearing: Jane Knox
Council for Exceptional Children, Division on Career Development and Transition: Pat Putnam and Carol Brito
Developmental Disabilities Planning Council: Tim Voz, Director, and Jim Crews
Governor's Committee on Concerns of the Handicapped: Sharon Cunningham, JTPA coordinator
Governor's Mental Health Planning Council: Pat Putnam, Carolyn Chimaya, and Carol Brito
New Mexico Deaf-Blind Program: Rachel Hammitt, program coordinator
New Mexico School for the Deaf: Gary Beeme, transition coordinator
New Mexico School for the Visually Handicapped: Thelma D. Swope, transition coordinator
Protection and Advocacy System: Ileana Johnson
Statewide Independent Living Council and Regional Independent Living Centers: Chris Isengard, Susan Lewis, and Rick Scifres
Statewide Transition Coordinating Council: Carol Brito, Statewide Transition Coordinator

American Indian Programs: Federal and Tribal
Bureau of Indian Affairs (BIA), Education Division: Lena Nez, Special Education; Bertha Muskett, Institutional Handicapped Program; Angie Yaza, Special Education; and Edie Morris, Special Education Coordinator for the Jurishky, NM BIA school
To investigate medical transition in New Mexico, literature searches were done and interviews held with the following personnel:

Pediatric Specialty Clinics, University of New Mexico
Adolescence Clinic: Victor Strasburger
Child Behavior Assessment Clinic and Children's Psychiatric Hospital: Bob Bailey
Endocrinology Clinic: Sue Scott
Gastroenterology Clinic: Ed Rose, Jeff Fahl
Genetics/Dysmorphology Clinic: Carol Clericuzio, Susan Root
Nephrology Clinic: John Brandt
Neurology Clinic: Leslie Morrison
Oncology: Stuart Winter
Pediatric, Adolescent and Young Adult Pain Management/Child Behavior Clinics: Eileen Yager
Programs for Children (autism): James Jenson
Pulmonary Clinic: Marsha Thompson

UNM Center for Development and Disability,
Jennifer Thorne-Layman, Director, Continuum of Care
Sherry Allison, Director, Indian Children's Program and Na'nitin (a training program for Navajo paraprofessionals to allow them to work more effectively with children with special needs and their family members)
Carolyn Richardson, Director, Leadership and Education in Neurodevelopmental Disabilities

Indian Health Service:
Dr. Marvin Godner, Pediatrics, IHS Hospital, Santa Fe
Dr. Kevin Sweeney, Chief of Pediatrics, IHS Hospital, Gallup,
Drs. Bill Gloyd and Paul Avritt, Pediatrics, IHS Hospital, Albuquerque.

Carrie Tingley Children's Hospital in Albuquerque
Dr. Fred Sherman, Director, and Dr. John Phillips, Director of Pediatric Rehabilitation.

Adolescent Health Specialists
Dr. Jane McGrath, Medical Director of the DOH's Office of School Health,
K. Ansbach of the New Mexico Chapter of the American Academy of Pediatrics,
Ronald Eager of the Rocky Mountain Chapter of the Society for Adolescent Medicine.

Income support and Medicaid coverage for youth with special health care needs in New Mexico were evaluated through literature research and interviews with representatives of the Social Security Administration and the New Mexico Human Services Department's Income Support and Medical Assistance Divisions.

The perceptions of youth with special health care needs and their families were explored in focus group discussions. Eight focus groups were scheduled including one mixed-age and one youth (ages 14-24) meeting per district. Of the 23 participants in the mixed-age focus groups, 6 (26.1%) were male and 17 (73.9%) were female. The average attendance at the mixed-age focus group meetings was 6 participants. Of the 19 participants in the youth focus groups, 11 (57.9%) were male and 8 (42.1%) were female. The average attendance at the youth focus group meetings was 5 participants. Best practices in the areas of medical services/wellness, career readiness and independent living were explored with experts in the field. Previous studies of transition in New Mexico, as well as current transition-related research and activities in the state were documented.

Needs Assessment Data Sources: Several needs assessments[29] conducted from 1998-2000 highlight areas of concern. These concerns include fragmented service systems, lack of cross-discipline communication and care coordination, and difficulty accessing dental services. These assessments also highlighted the need for an increase in public information and awareness for services available for CSHCN as well as opportunities for families to learn how to self-advocate for their children's need within today's complex health care delivery system.

1. SSDI Funding for Assessment: Three contracts were issued to conduct assessment work:

a. The MCH Epidemiology Program contracted with a MPH prepared epidemiologist to do analysis on several of the new health status indicators as well as analysis of live birth data for gaps and disparities.
b. The SSDI Project Director successfully abstracted information from the County MCH plans and Head Start Community Assessments. As outlined in the SSDI work plan, this contract also developed protocols for conducting group discussions in FY 2001.
c. The MCH Epidemiology Program contracted with a statistician to construct a MCH County Level vulnerability index. The index comprises four sections of 5 indicators in each set: socio-economic data, access to health care data, health behavior data and health outcome data that were be

calculated to z-scores. The project's goal is to use data to identify geographic areas (counties) by level of vulnerability to health problems. Follow up assessment will be conducted in FY2001. A preliminary copy of this report is found in the Appendix.

2. Child Health Insurance Status: Three sources of data were used; the Current Population Survey of the Census; a 1999 telephone survey of Health by the NM Health Policy Commission; and NM PRAMS. The NM BRFSS Project mounted specific questions on child health insurance coverage for Years 1999 and a revised, expanded set of questions for Year 2000. The 1999 data will become available in November 2000.

3. Children with Special Health Care Needs, Medical Home and Impact of Medicaid Managed Care survey and focus groups: A survey of Medical Home Practice Standards was sent out to 400 physicians in New Mexico. The survey included practice of accessibility, family centered, comprehensive, continuous, coordinated, compassionate and culturally competent care. With a 52% response rate, the majority (74%) said they would be interested in training about the Medical Home concept. Response summary: Of the 400 surveys sent out, 55 responded by saying they do not see CSHCN leaving a valid denominator of 345. Thus of the 180 respondents, the response rate would be 52% (180/345). Of those who responded; 74% were Pediatricians, 40% were Family Practice and 24% were Pediatric Specialists

4. Medicaid Data for Potential Eligibles, Eligibles and Recipients: Census data was used to estimate potential eligibles, based on a 1990 census figure of 64% of children <20 at 185% of the FPL. Data from 1990-1998 was abstracted from the Health Care Financing Agency (HCFA) reporting form 2082 for New Mexico. Prior to 1998, NM Medicaid was not in the MSIS system. State totals for children under age 1 are overstated by as much as 50% in the non-MSIS states. During this period, NM used the hard copy 2082 reporting form, which include 6 months of extra data. This comes from a Medicaid HCFA guideline regarding how to construct reports. Some states, including New Mexico, show more recipients than eligibles for certain cells, especially where numbers in cells are small. It can be a result of expansion of recipient counts for services prior to the reporting year, shifts from unknown categories or misreporting by states. These limitations date back to 1995 as well. (www.hcfa.gov/medicaid/caveat96.htm) The 1997 caveats and limitations (at the same website) stated that from 1996 to 1997 the number of eligibles may drop due to welfare reform, delinking with Medicaid and changing economic conditions on Medicaid enrollment. The same caveats as in 1996 prevailed. New Mexico became an MSIS state in 1998.

It is well known that infants and young children are high users of Medicaid and children from age 10-20 are generally low users. It appears that those who obtain Medicaid benefits utilize the services, however, some would consider this an over-estimation. The Information System specialists in the Medical Assistance Division (MAD) use these guidelines for using the data:

a. Infants <1: the number of eligibles is affected by the non-MSIS situation and is inflated by as much as 50%. It should be used as proxy for the number of recipients. The high number of recipients occurred because MCO's are learning new data systems and it is thought that for this age, it might be encounter data. Nevertheless, the root of the problem is not perfectly understood.
b. Children ages 1-5: the eligibility data is approximate reality but recipient data looks high.
c. Children and youth ages 6-14 and 15-20: the data are a reflection of managed care reporting. The billing is based on capitation, so it would appear that recipients approximate eligibles.
d. Encounter data will be needed for Title V MCH monitoring of data. Encounter data from January-March 2000 is considered the first quarter of correct encounter data because of the time it has taken the Medicaid MCO's to integrate the new systems. The MAD staff was very helpful in sorting out the problems with the data.

5. Youth Risk Behavior Survey (YRBS): The YRBS was administered in Spring 1999 for the first time since 1995. In addition to 87 core questions from the CDC YRBS, the questionnaire had 30 additional items: 10 demographic and 20 regarding perceptions of norms regarding substance abuse. The sampling frame consisted of all public high schools in NM. The sample was drawn using PCSample, a product of Westat, which stratifies by school and by classroom. Surveys were sent to 896 students in 56 schools; 37 schools participated with 568 surveys. The response rate was 41.6%. The largest school district in the state (Albuquerque) did not participate. Thus, the results are aggregated but are not representative of all NM students; rather only those school districts that did participate. The last YRBS that was representative was in 1991 (N=3,137). Questions in 1991 were different from the 1999 questions, thus comparisons are not easily made. The 1993 YRBS (N=1,714) was also not representative but the questions were sufficiently similar to the 1999 questions that some comparisons can be made. The 1995 YRBS was too small for comparisons. In addition to the statewide survey, 47 of 57 school districts conducted the 1999 YRBS at a district level. This effort was made in order to get much sought after community level data. This effort was funded separately under CSAP funding.

6. Double Rainbow Project Family Survey: The 1999 statewide family survey was funded by the US Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Integrated Services Branch as part of project 351S19. The goal of the project is to identify ways to improve early intervention and health service systems in New Mexico so families can access needed services. The survey of 302 families concluded that service barriers for special needs children include: accessing special medical equipment and supplies, lack of pediatric dental services, lack of easily understood health information and lack of services offered by the NM Family Infant Toddler (FIT) system and Medicaid Salud! The Family Health Bureau is an active participant in the Double Rainbow Project and several of its work groups.

7. New Mexico School Survey (NMSS): of 1997 was based on a sample of nearly 27,000 students representing 72% of the state's public school population grades 7-12. Every county except for Bernalillo is represented in the NMSS; 77 of the 89 public school districts participated. The survey reports gender, grade, race-ethnicity, family composition, measures of poverty, grades in school, parental rule setting, adult mentors, after school time, violence, problem behavior, depression, self-esteem, substance use by tobacco, alcohol, marijuana, other drugs, and sources for getting substances.[30]

8. Youth Development Assets: 56% (18 of 33 counties) have adopted the Assets model; an increase of three counties from last year. By the year 2002, increase the number of counties adopting the assets model by or 2 counties to increase to 62% the total number of counties adopting the assets model. 47,000 students completed the survey, Search Institute Profiles of Student Life Attitudes and Behaviors, which reports individual assets of each student This is an increase of 13,800 students from the previous years. The goal is to increase the number of students completing the survey by 20% or 9400 students by 2002.

9. Sexually Transmitted Diseases (STD): A new CDC generated STD management information system was introduced in 1999. Data prior to this were collected in an Epidemiology Information data system designed for the STD program in the PHD. Data entry support was sporadic in 1997-98 and thus many data entry errors were made. The 1997-98 low counts for Chlamydia will be adjusted based on previous data in order for the total to be a reasonable estimate.

10. Vital Records, Birth files: While the majority of data elements are complete in NM birth files, information on the father's age and race is missing in more than 26% of records; an even higher proportion for teen mothers.[31]

11. Linked Birth to Death files: New Mexico has linked birth and death files for several years. This report features results of a 10-year retrospective analysis 1988-98. The CDC Wonder site provides linked birth death information for 1995-1997 for New Mexico.

12. Maternal Mortality: This study links Maternal Death to Birth and Fetal Death files. While the New Mexico death certificate has a marker for "if the decedent was pregnant within 42 days of the death" linking female death files to birth and fetal death files does an even more complete ascertainment. This linking was done from 1994-1998 and the 1999 linked files are pending. The cases are referred to the NM Maternal Mortality Review team for review. Additionally, the files of the Office of Medical Investigator (OMI) were searched from 1980 to 1999 using pregnancy as the search criteria. These cases were abstracted into a report showing pregnancy related and pregnancy associated deaths.

13. Linked Data Files with Vital Records:

a. Linked Birth to Medicaid files: Birth files were linked to Medicaid files for 1995-1996. The project is being resumed; the 1997 linked report may be complete in Fall of 2000.

b. Linked Birth to WIC files: Both VRHS and WIC programs have agreed in principal to the advantages of this study.

c. Linked Birth to Newborn Genetic Screening files, State Laboratory Division: one attempt was made with a 75% match rate. The link found less than 99% of newborns had genetic screening pointing to the need to evaluate characteristics of those not screened for outreach purposes. This data is incomplete, inaccurate, and reflects the inability to link the data sets. New software with appropriate linking capacities was recently purchased allowing for more accurate data in future reports. Estimates to date reflect a 97% match rate.

d. Linked Birth to Children's Chronic Conditions Registry (3CR): Birth files are linked to 3CR to establish more accurate prevalence of birth defects specifically Neural Tube Defects (NTD) and Oro-Facial Cleft. The NM Birth Defects Prevention and Surveillance System (BDPASS) project, funded partially by a CDC Grant USD/CCU 616078, includes NTD occurrences and recurrence, prevention, and surveillance activities.

14. NM Pregnancy Risk Assessment Monitoring System (PRAMS) data for 1997-1998 was used extensively. For this period, New Mexico PRAMS data files comprised 2,577 mothers with an overall response rate of 66%. The distribution in the PRAMS sample for race-ethnicity, age distribution and maternal education levels approximated the birth population. The 1999 NM PRAMS sample file closed in June 2000 with an overall response rate >70%. PRAMS is supported by Title V MCH, a CDC cooperative agreement 1996-2001 and Medicaid based on a non-federal match.

15. Hospital Inpatient Discharge Data (HIDD), New Mexico Health Policy Commission: The HIDD collects discharge data from community and selected specialty hospitals. It should be noted that the HIDD does not include data from Federal Hospitals including IHS hospitals in New Mexico serving urban and reservation Indians and military hospitals. Since 1995, data have identifiers that make it possible to assess unduplicated hospitalized persons as well as total hospitalizations. Billing was added to the database in 1998 but not yet assessed in DOH analysis projects. Three analysis projects were conducted using HIDD data and used in this assessment:

Non-Fatal Injuries: Hospital Inpatient Discharge Data (HIDD) injury discharges for 1998 were evaluated by Barbara Chatterjee MS, Injury Epidemiologist and Kathy Goodyear, HPC data manager.[32] E-codes are not a required data field in HIDD submissions and thus E-coding is incomplete in the files. As a result, only 59.5% of the 15,671 injuries were E-coded so the data is incomplete. The FHB Epidemiology

Program did the compilation of injuries by mechanism in rank order and intent by proportion. Because of data gaps, findings are not released this year.

Pregnancy Morbidity: HIDD discharges for antepartum hospitalizations in 1995-96 were evaluated by Melissa Schiff MD, and Kathy Altobelli MS statistician, both from the University of New Mexico. Susan Nalder PhD, Epidemiologist from the FHB also participated. (See Appendix).

Asthma Hospitalizations: Data Information: Asthma Hospitalizations, ICD Code Range 493 to 493.91in children and NM of all ages were evaluated by Laura DiGrande, MPH and Susan Nalder. (See Appendix).

16. Children's Medical Services Cultural Competence Self-Assessment: In January of 2000, the Children's Medical Services undertook a cultural competence self-assessment. The following summary is a condensed version of the preliminary assessment results prepared by Georgetown University. (See Appendix).

The Georgetown University National Center for Cultural Competence (NCCC), MCH/CSHN component, selects several states and local communities annually as demonstration sites which receive intensive technical assistance in order to increase the capacity to serve culturally and linguistically diverse children and families. The NCCC conducts cultural competence organizational self-assessments with local CSHN and MCH programs and provides consultation and other resources for the development and implementation of agency specific cultural competence plans. New Mexico State Title V Program, Children's Medical Services (CMS), was selected as a NCCC's demonstration sites.

Summaries of the Focus Groups key points are as follows:

1. Lack of availability of appropriate linguistic services within the hospital environment; communication of medical issues difficulties between professionals and families; need for more response to family questions and concerns; linguistic and cultural biases and insensitivity to family's economic circumstances; need for cultural sensitivity regarding privacy issues; lack of respect for family's time and responsibilities in terms of scheduling.

2. Families expressed a need for humanized treatment, medical provider training re: psychosocial and cultural issues; need for availability of professional interpreters within hospital environments; need for knowledge and appreciation of alternative health practices; need for providers to have more education about specific medical conditions; need to respect families opinions and their role as decision makers in the care of their children; need for families to have sufficient care information upon release from hospital and in-home and outpatient follow-up in the community.

3. Family members expressed concern about the larger service delivery system, especially about stereotyping and threats of deportation.

Recommendations for CMS included: increasing pediatric specialists and more geographically accessible specialists; financial support for travel and accommodations for family members; increased community outreach for CMS services; more brokering and information sharing, need for specialized training and plan for adolescents; and the need to take psychosocial aspects of family life into consideration.

The Administrator and Service Provider Self-Assessments were very similar in their outcomes.

1. Strengths included the ability to provide support to Hispanic and Native American communities; service delivery and support; personal involvement with Hispanic and Native American communities; moderate degree of professional and social linkages with these two communities. Providers showed strength in knowledge and use of community resources. Administrators showed strength in knowledge of culturally competent approaches to service delivery and practice. Workforce at the service delivery level is diverse, with high representation of bilingual, Spanish speaking staff. The greatest strengths included support, outreach to community-based organizations and consideration of culture in treatment plans.

2. Growth issues included: more expertise, knowledge and involvement with Asian, Pacific Islander population and African American communities. This area for growth addresses the needs of smaller populations within the state. Need for outreach to traditional healers, natural networks of support, and clergy or places of worship. Very little of the programs work around cultural competence has been legitimized in program policy.

The Families/Consumers focus groups recognized the following:

1. Strengths included: allowing consumers to express their views; familiarity with languages; and awareness of child health issues; considerable involvement in cultural and ceremonial events; excellent ability to work with community organizations and diverse communities; culturally and linguistically diverse staff; very high sensitivity in communicating with families regarding service delivery approaches.

2. Growth issues included: need for increased knowledge of traditional healers, natural networks of support, and clergy or places of worship. Needs for staff to address issues regarding safety in the community, i.e., home visitors, were also raised.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

The priority health status problems of the MCH and CSHCN populations are attributed largely to problems associated with living in poverty, working families with too few resources and the health problems associated with health risk behaviors. The state has too few services for prevention, screening, treatment and counseling for those who have problems with tobacco, alcohol and other drugs. Significant gaps in health status measures are seen for minority populations, although it is not understood if this is a function of poverty, factors unique to specific minority group experience or some other set of factors. In previous decades, the Title V MCH programs provided a large safety net for mothers, infants, children and CSHCN through direct and enabling services. Local health offices throughout New Mexico offered a core of prenatal, well child and adolescent health care. This safety net is now much smaller with focus on specific areas. Populations that are not eligible for several of the state and federal programs are at greatest risk. There are no estimates of undocumented women by health indicators and who are in need of prenatal, family planning, preconceptional and primary care services.

While a large portion of New Mexico's children live in poverty, participation in the Food Stamp program has declined. Participation in the School Food Program is also low. There is very limited access to nutrition assessment and counseling. The Maternal Health Office carefully reviewed the spending patterns of the High Risk OB Fund. This revealed that there was a network of providers who were alerted to this part of the safety net as a payor of last resort for non-Medicaid eligible women. Applications to this fund continue to exceed its available resources. New sources of funding may be necessary to ensure viability. A database is being constructed to provide information on providers, clients, services and birth outcomes.

This comprehensive 5-year assessment of the MCH population is organized into sections according to the population-based assessment and planning needs of the MCH programs. As a group, Children with Special Health Care Needs (CSHCN) are integrated into Sections B and C. Infant health is described as a unit in Section B. There are three groups presented on this overview of health status:

A: Health of Reproductive Age Women Age 15-44, with Emphasis on Preconceptional Health and Health During And After Pregnancy
B: Health of Infants, Toddlers and Children Age 0-9 Years
C: Health of Pre-Teens, Teens and Youth, Age 10-24 Years

A: Health Of Reproductive Age Women Age 15-44 Years With Emphasis On Preconceptional Health And Health During And After Pregnancy

The following domain wheel visually depicts the areas of importance for this age group.

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Lifestyle:
-Smoking
-Sedentary/Active
-Nutrition/Obesity/Eating Disorders
-Seat belt use
-Guns in home, life
-Affinity pattern
Models (Family)

Violence
Alcohol
Substance Abuse
Tobacco

Employment:
-Hours
- Wages
- Health Risks
- Meaning/ Satisfaction
- Authority
- Child Care Availability
- Transportation
- Competition

Social Support:
-Assets/Resources
-Family Configuration/Strengths/Stress
Child Care/ Child Support
-Parenting Support
-Safety of neighborhood -Role
-Emotional support

Basic Needs:
-Shelter
-Food
- Hygiene

Personal Power
-Access to Policy Making
-Access to Resources
-Education
-Power within the Home

Reproductive Age Women
(12-55 yrs, approximately)
Sociodemographics:
Population, ages, ethnicity, income level by age, educational level, legal status, marital status, ability to read, ability to speak English

Education
-Pub/Priv/Hom
-Continuing Ed.
-Literacy
-English As 2nd
-Job Training
-Health/Nutrition
-Parenting

Environmental
-Water
-Air
-Radiation
-Toxics

Quality:
Health Status:
-Mortality/Morbidity
-Causes of Death/Years of Life Lost
- STDs
-Chronic Diseases
Diabetes
Cancers
HIV
Hypertension
History:
Genetic Disorders
Dental Status
Disabilities
Depression
Other psychiatric disorders

Spirituality
-Cultural Beliefs and Support
-Belief System
-Religious Institutions

Access to and Utilization
of Direct Health and Health-Related Services:
-Insurance/Type
-Pap in last 2 years?
-Barriers to services within last year
-Transportation

- Dental
- Satisfaction w/ Care

Reproductive
-Fertility rate
-Birth rate (age, ethnicity, income)
-Mortality/Morbidity
- Birth outcomes (genetic/ special health needs

-# Children born
- Level prenatal care
- Family Planning(FP) Methods,
 # and % Unplanned pregnancies,
Barriers to FP: cost, availability
-Religious beliefs

1. Priority Health Issues For Women: District and local MCH program staff were highly aware of the morbidity, mortality and health behaviors that are substantiated by data for this population group. Across all four Health Districts statewide, staff reported these health status issues:

Life Circumstances

- Social Isolation: effecting many young women and new mothers

Health Status Problems (morbidity, mortality, injury, disability)

- Mental Health: depression in women, possibly greater problem among Spanish speaking women who have few if any health care providers who speak Spanish and understand cultural issues
- Teen pregnancy: pregnant and parenting teens
- STDs: among women, youth
- Unintentional injuries, primarily motor vehicle crashes

Healthy and Health Risk Behaviors

- Smoking: women, youth and exposing children at home to smoke
- Alcohol and Drug Use: women, youth and exposing young children to risks of injuries when adults drink
- Domestic Abuse: effecting women, youth and young children who witness domestic abuse or become victims of abusers.

Environmental Health Problems

- Water quality in many counties

Lack of Health Services (clinics, providers, specific services)

- No prenatal care and education throughout the state.
- Lack of School Based Clinics in Rio Rancho and Cuba.
- Lack of hospitals, OB or pediatric providers in several counties.
- Lack of mental health and substance abuse treatment services; lack of recognition and treatment of depression, especially for Spanish speaking. Sliding scales for mental health are too high and create barriers for families to receive care.
- Lack of breastfeeding education.
- Lack of a primary care center or a “women’s wellness center”.
- Lack of dental providers that accept Medicaid
- Vision and dental services for uninsured is limited or non existent
- Lack of smoking prevention/cessation education /support and limited provider choice.
- Need more comprehensive health care

Need Community Based System of Care

- Need a referral network for problems identified in clinics
- Dona Ana and Bernalillo county have an abundance of resources including rural primary health centers and private physicians yet there is a lack of coordination and accountability of services across systems

Lack of Support Services (Health Related, Social, Child Care)

- Lack of adequate childcare/Head start
- The lack of health education in schools, Sex-education is being taught too late in schools. “Need to access age of conception and educate before that age”. “We are now seeing one teen male with more than one pregnant girlfriend.” We need the school district’s involvement in district health planning efforts.

Problems of Health Care Costs and Health Insurance

- Lack of sliding scale health care
- Lack of health care services for men and women 18+ who do not want family planning services. Children's Medicaid covers children 0-18 years. Category 35 F family planning Medicaid covers women of reproductive age for family planning 19 and up. There are men and women 19-64 who may not have health care coverage until they are eligible for Medicare.
- Women aged 19-65 (not pregnant, not eligible for Medicaid and without employment coverage) have problems accessing direct health

Barriers to Health Services

- Border area community providers (Midwives and OB's) are finding an increase in the number of women who are not receiving prenatal care. Providers state that women are not receiving prenatal care because of transportation needs.
- ISD worker(s) are "rude to clients and that's why they go elsewhere for assistance with MOSAA; ISD needs to be more supportive."
- Postpartum care for women who have been dropped from Medicaid and asked to reapply for 1115 waiver
- Access and utilization of services is complicated by severe decrease in staff within the "system". There is a need for medical interpreters during labor and delivery as well as other times.
- Better systems for getting women and children enrolled in health insurance plans
- Need a class in Medicaid (Medicaid clients refuse to use services or do not know no to use system);
- The time it takes to schedule appointments for prenatal care in the MCO environment.

Social Determinants of Health

- Access to health and prenatal care difficult. There are transportation needs, lack of jobs and Medicaid providers. Income per capita is low. Teen pregnancy, DWI arrests, alcoholism and domestic abuse rates are increasing. Teen suicide is also of concern.

Safety Net Issues

- Where/how do the undocumented and adolescent populations access FP/STD and prenatal care if Public Health is not there?
- Access issues include poverty, housing and transportation, afterschool programs, affordable day care, lack of comprehensive insurance for women and children.
- Many services are not available for the undocumented population

Quality of Care Issues

- Qualities of selected kinds of services: education of staff and others (UNM medical students, residents, etc.) on issues around referrals, sources, and social issues.
- Quality prenatal exams vary depending on women's medical coverage, life style and education
- Quality of selected kinds of services include lack of confidentiality in health offices contribute to why teens don't want to go for family planning services; "we need to work on providing real conditions of confidentiality so kids in small towns don't fear seeking services to prevent rumors such as, 'I saw her in the FP clinic so she must be having sex.' "
- There is need for routine assessment regarding women's satisfaction with access to and availability of reproductive care and quality of care received. Additionally, there is a gap in marketing and getting information to women of greatest need.

As with all other population-based assessment groups, the issues of access to and use of health and health related services was the leading concern. See more on this in the section on Direct and Enabling Services.

2. Sociodemographic and Economic Overview: In 1997-98, women aged 14-44 comprised about 20% of the state population with a total number 324,000.[33] A majority of women are Hispanic, American Indian or African American. An estimated 23.3% women age 15-44 live at or below the Federal Poverty Line (FPL). Of women age 20-44, 16% live at or below the FPL; 31.6% live at or below 185% of poverty.[34] Many are single parents with children struggling to keep a family together while working a low paying job. Nearly 30% report no access to health insurance.

3. Preconception Health Issues: Preconception health refers to the health and well being of potential parents before their first pregnancy and between all subsequent pregnancies. As a society, this concept has implications for programs and policies to address many dimensions of women's health, family health, maternal and infant health. The Title V MCH program, the Title X Family Planning Program nor the Title XIX Programs of HRSA and HCFA do not have integrated comprehensive programs that recognize the importance of preconception health. Each of the federal programs has selected policies and interests. It falls to the state to bring these resources together to address the following kinds of preconception health issues:

Intention of Pregnancy: An estimated 46% of state births in 1997-98 were unintended meaning the mother would have liked to become pregnant later or not at all. This proportion was higher among teen mothers. When pregnancies are unintended it is unlikely that potential parents are adopting healthy behaviors for a developing fetus prior to conception. Unintended pregnancies are associated with poor outcomes of pregnancy and problems in parenting or care taking behaviors as well.

Use of Alcohol: An estimated 44% of women used alcohol in the three months before pregnancy. Fetal Alcohol Syndrome (FAS) occurs in 1/1000 NM Births; Alcohol Related Birth Defects are estimated to affect 1/100 infants and children.

Use of Tobacco: An estimated 24% of women reported smoking in the three months before pregnancy.

Folic Acid Awareness: An estimated 31% of women age 18-44 reported knowing about the protective effects of folic acid on reducing the risk of birth defects in 1997.[35]

Intimate Partner Violence, Abuse: An estimated 11% of New Mexico women reported being physically abused in the 12 months prior to pregnancy.

Figure 1: Preconceptional Health Care and Support, New Mexico

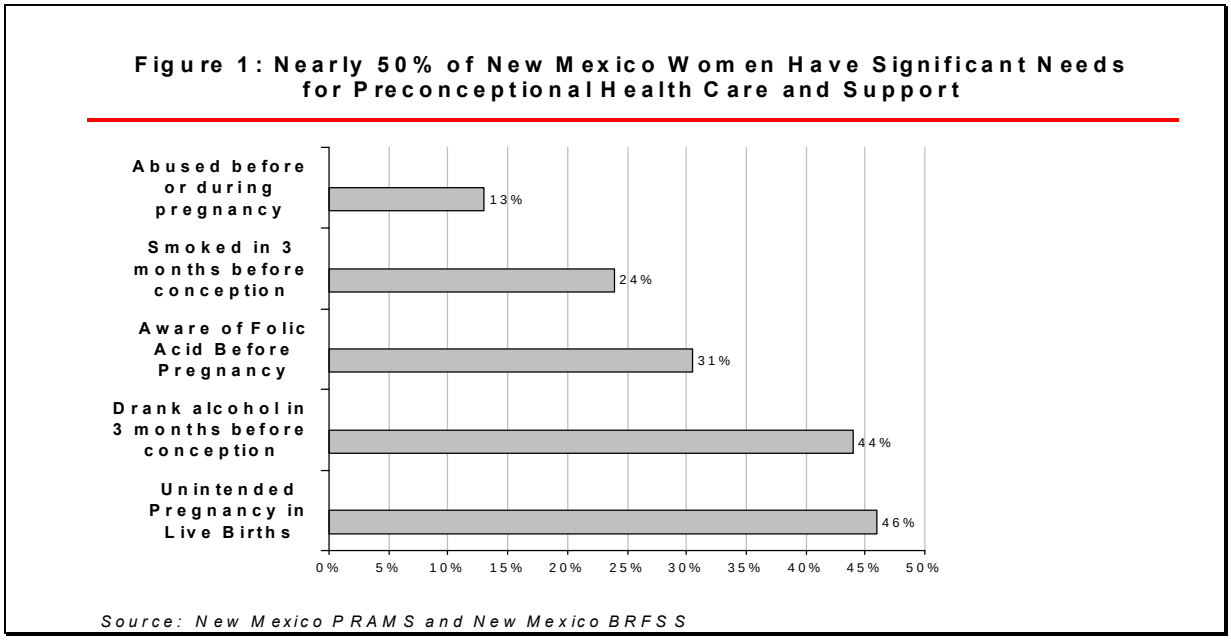
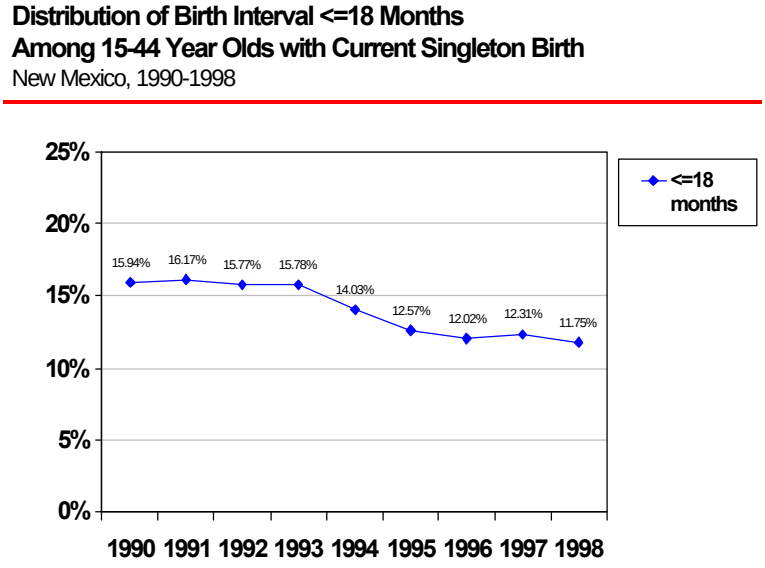


Figure 2: Interpregnancy Interval



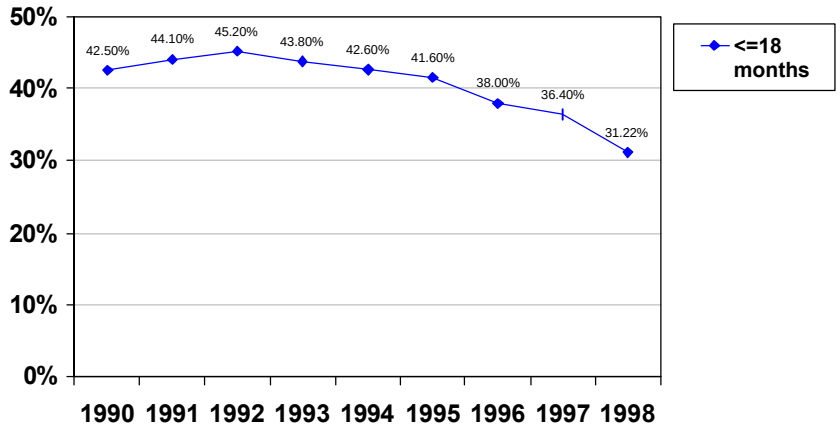
Definitions: Inter-pregnancy interval is a dichotomized variable. It quantifies the percent of women age 15-44 with a repeat pregnancy (present live birth);
Singleton births excludes twins and triplets among present live birth.
Source: New Mexico Vital Records and Health Statistics Birth Files.

A short inter-pregnancy interval is associated with an increased risk for preterm delivery, low birth weight and infant mortality. Among women ages 15-44, the proportion with a short inter-pregnancy interval declined from 15.95% in 1990 to 11.75% in 1998. Among teens age 15-19 having a second or higher

order pregnancy, the proportion with a birth interval < 18 months shows a declining trend since 1990 (42.5%) to 1998 (31.2%).

Figure 3: Teen Inter-pregnancy Interval 1990-1998

TEENS: Inter-pregnancy Interval
15-19 year olds whose current birth is singleton
New Mexico, 1990-1998



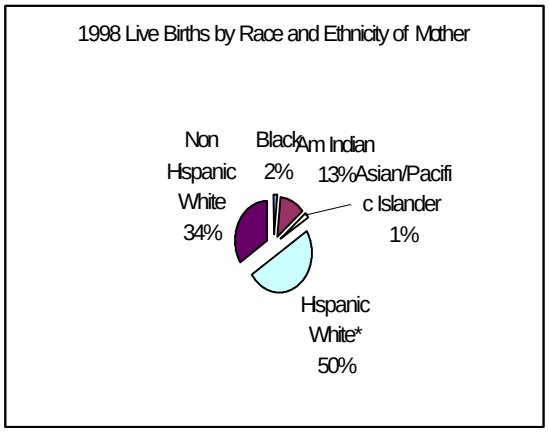
Definitions: Inter-pregnancy interval is a dichotomized variable. It quantifies the percent of women age 15-44 with a repeat pregnancy (present live birth);
Singleton births excludes twins and triplets among present live birth.
Source: New Mexico Vital Records and Health Statistics Birth Files.

The 6-year average for 1992-1998 for New Mexico counties showed that a short interval ranged from 9.21% in Taos County to 16.53% in McKinley County; in Bernalillo County it was 12.3%.

4. Natality and Fertility Status, Trends and Disparities: The number of births in New Mexico has declined since 1995; in 1998, there were 27,318 births. Only Nebraska and Nevada had a comparable number to New Mexico with both of those states also having a large territory and a relatively sparse population. From 1990-1998, the New Mexico birth rate declined as well. However, the state birth and fertility rates are relatively high to the national average. In 1998, the birth rate in New Mexico was 15.7/1,000 placing the state 9th highest in the nation. From 1990-99, the fertility rate declined; in 1998, this rate was 72.2/1,000 women age 15-44 placing the state 7th in the nation.[36]

Births by Race and Ethnicity: In 1998 the majority (65.3%) of births were to a minority group: Hispanic White: 49.6%; American Indian: 12.5%; Black: 1.86%; Asian and Pacific Islander: 1.4%; and Non-Hispanic White: 34.6%. Among the 13,714 Hispanic New Mexican births, 65% were native to New Mexico; 33.4% were of Mexican heritage; and the rest were of Puerto Rican, Cuban or Central/South American heritage.[37]

Figure 4: Live Births in New Mexico and Mother's Ethnicity



In 1998 an estimated 44% of births were to single mothers placing NM in 3rd place in the nation; 4th if Washington DC is included for this indicator. This ratio is higher among Native American mothers whose cultural norms regarding childbirth and marriage differ from mainstream national culture. Rates higher than 44% were also reported for Hispanic mothers at 50.2% and for Black mothers who make up <2% of births.[1]

5. Teen Pregnancy and Births

In 1997, New Mexico ranked 48th worst in the nation with for percent of births to teens <age 20 at 17.9% of total births (National average 12.7%, range 7.4% in Massachusetts to 20.7% in Mississippi). In the same year, New Mexico ranked 20th in the nation for the percent of teen births to mothers who were already mothers at 19.6% (National average 21.6%, range 13.5% in Vermont to 31% in the District of Columbia).[38]

Age 15-17: In spite of recent downward trends in the United States and in New Mexico, the rates for teen pregnancy or teen births in those age 15-17 have not appreciably declined since 1980. Between 1980-1998, there has been a slow but gradual increase of 0.6 in the rate per year in the birth rate; similarly between 1990-98 a gradual increase of 0.56 per year; between 1993 and 1998 a decline of -1.17 in the rate but not statistically significant. Thus there were variations with birth rates as high as 52.6/1000 in 1993; but the rate in 1980 of 43.9/1,000 is only slightly higher than the rate of 43.5/1,000 in 1998. Pregnancy rates are somewhat lower with a decline in the abortion ratio for this age group from 14 in 1980 to 11 in 1998. The pregnancy rate in 1980 of 58.2/1,000 is higher than the rate of 54.8/1,000 in 1998. Rates varied significantly by county, from a low of 17.5 in Los Alamos (the most affluent county in the state) to a high of 76.4 in Socorro County.

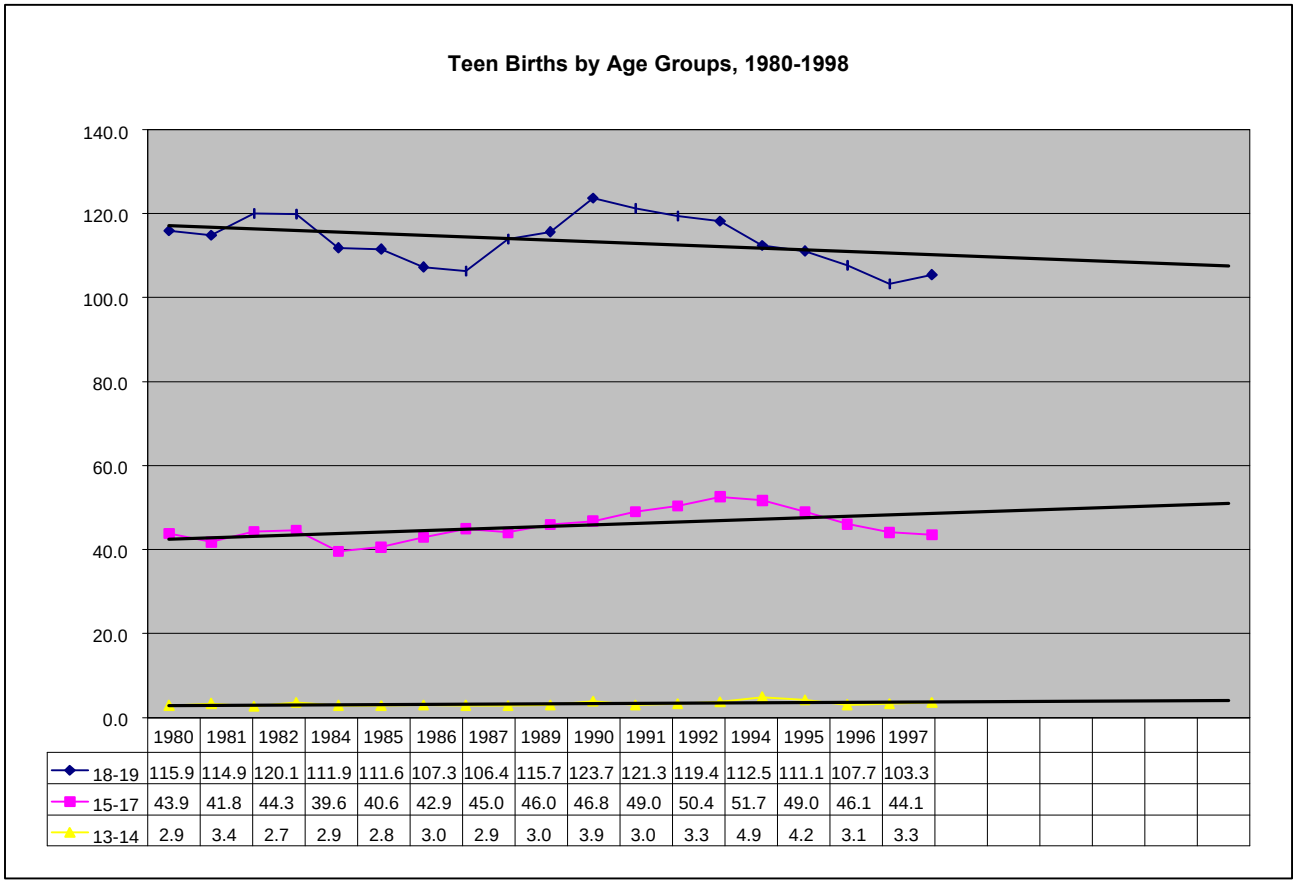
Age 18-19: The birth and pregnancy rates for teens 18-19 declined for the period 1980 to 1998. As with younger teens there has been variation in rates with a high of 123.7 in 1990; yet the rate of 115.9 in 1980 was ~10% higher than the rate of 105.5/1,000 in 1998.

Age 13-14: The birth and pregnancy rates for teens age 13-14 show a disturbing increase between 1980 and 1998. In 1980 there were 66 live births and 35 abortions; in 1998 there were 103 births and 43

abortions. Birth rates were 2.9 in 1980 and 3.6 in 1998; Pregnancy rates were 4.4 in 1980 and 5.1 in 1998, a 13% increase. The abortion ratio has shown variation between 1.2 and 2.0.

The following figures depict age specific trends in teen birth rates since 1980 and predictions through 2005, if all factors operating remain constant. It suggests for 18-19 year olds there will be a decline in rates from 115/1,000 to 110/1,000; for 15-17 year olds an increase in rates from 43.9/1,000 to >50/1,000 by 2005; and for 13-14 year olds the rates are predicted as showing a very slight increase from 2.9/1,000 to 4/1,000.

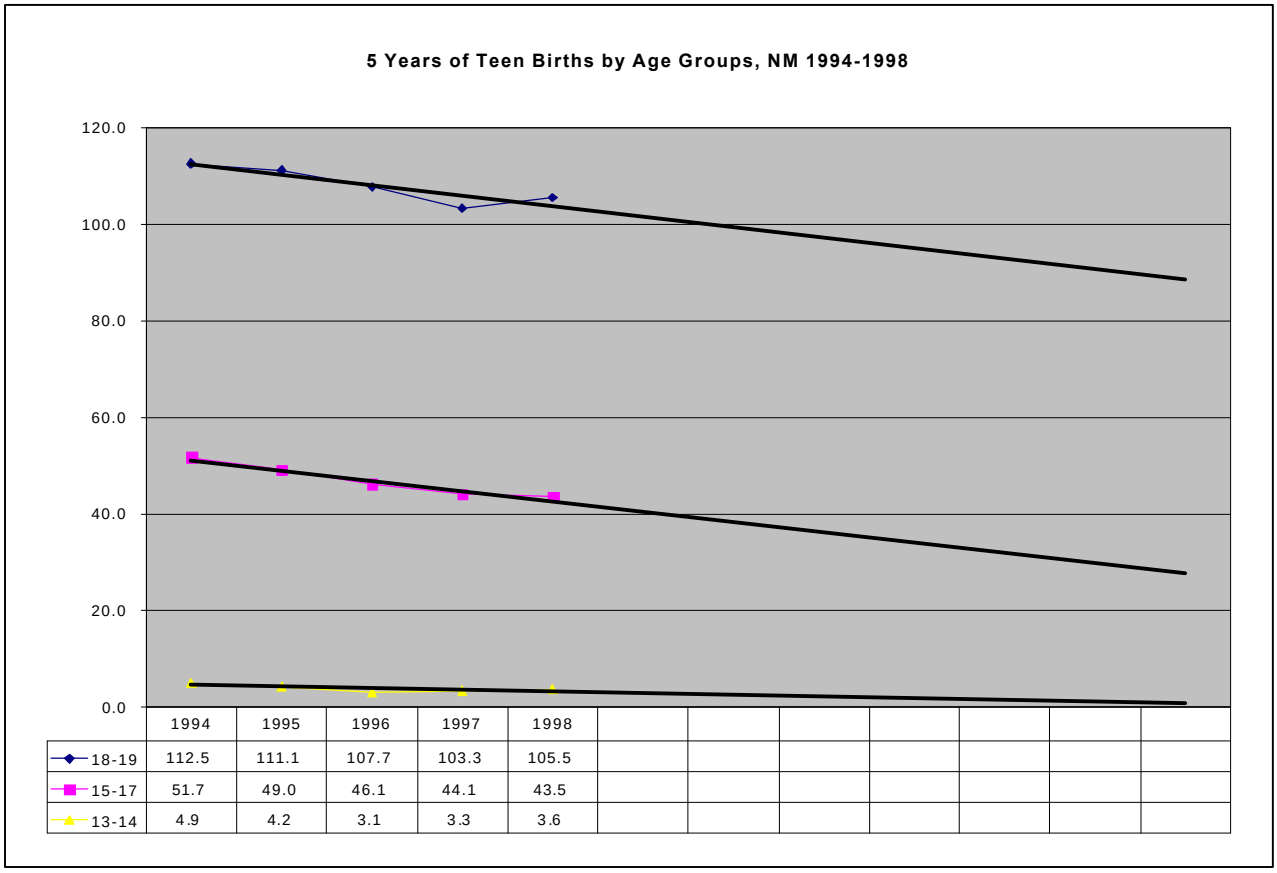
Figure 5: Ten Years of Teen Births 1980-1998, Showing Trend Line



	1980	1981	1982	1984	1985	1986	1987	1989	1990	1991	1992	1994	1995	1996	1997
18-19	115.9	114.9	120.1	111.9	111.6	107.3	106.4	115.7	123.7	121.3	119.4	112.5	111.1	107.7	103.3
15-17	43.9	41.8	44.3	39.6	40.6	42.9	45.0	46.0	46.8	49.0	50.4	51.7	49.0	46.1	44.1
13-14	2.9	3.4	2.7	2.9	2.8	3.0	2.9	3.0	3.9	3.0	3.3	4.9	4.2	3.1	3.3

The following figure depicts age specific trends in teen birth rates since 1994 and predictions in rates from 112.5/1,000 to 901,000; for 15-17 year olds a decrease in rates from 51.7 to 30/1000; and for 13-14 year olds a decrease in rates 4.9/1,000 to <2/1,000.

Figure 6: Five Years of Teen Births in New Mexico 1994-1998 and Predictions for 1999-2005



	1994	1995	1996	1997	1998
18-19	112.5	111.1	107.7	103.3	105.5
15-17	51.7	49.0	46.1	44.1	43.5
13-14	4.9	4.2	3.1	3.3	3.6

There are significant disparities for teen birth rates, ages 15-19, by race and ethnicity. The overall rates varied from a low of 46.9 in 1990 to a high of 54 in 1993; declining to 47.1 by 1997. Lacking current denominators by race-ethnicity, the raw numbers suggest all teens will continue to have a slight increase; with increases in Hispanic White teens and decreases in non-Hispanic White, Black, American Indian teens. Teen pregnancy prevention continues to be a challenge. The Department of Health is committed to work on using all types of interventions from health education, asset development, traditional family planning methods and abstinence only education.

Morbidity In Women, Status, Trends And Disparities

6. Sexually Transmitted Diseases (STD) in Women, Age 15-44: Chlamydia infections indicate the risk of unprotected sex by age, race and ethnicity and county; undiagnosed infections may lead to infertility and the increased risk of ectopic pregnancy.[39] STD's are generally considered to be under-reported.

Age: The risk of Chlamydia infection in teens 15-19 is only marginally higher than the risk for young women age 20-24; teens bear three to five times the risk for women age 25-44. The Chlamydia rate for teens is approximately ¼ the pregnancy rates ~83/1,000 for age 15 -19 in period 1997-98. In 1999 there were 67 cases in girls age 10-14, a rate of 0.9/1,000 girls. The pregnancy rate was 2.1/1000 in 1998.

Pregnancy and STD's in girls 10-14 are a serious problem associated with rape and/or incest, with increases in recent years.

Race and Ethnicity: Using 1999 data, Black women comprise <3% of the population yet 9% of cases; Hispanic women comprise ~40% of the population and 56% of cases; the proportion of Indian population to cases (11%) is within proportionate range; cases in the Asian population were virtually non-existent; and cases (15%) among non-Hispanic whites were lower than the population (40%). Although males comprised only 17% of reported Chlamydia cases, the distribution of cases by race and ethnicity was remarkably similar. The root cause of these remarkable racial-ethnic disparities is unknown.

Figure 7: Chlamydia Infections New Mexico 1995-1998

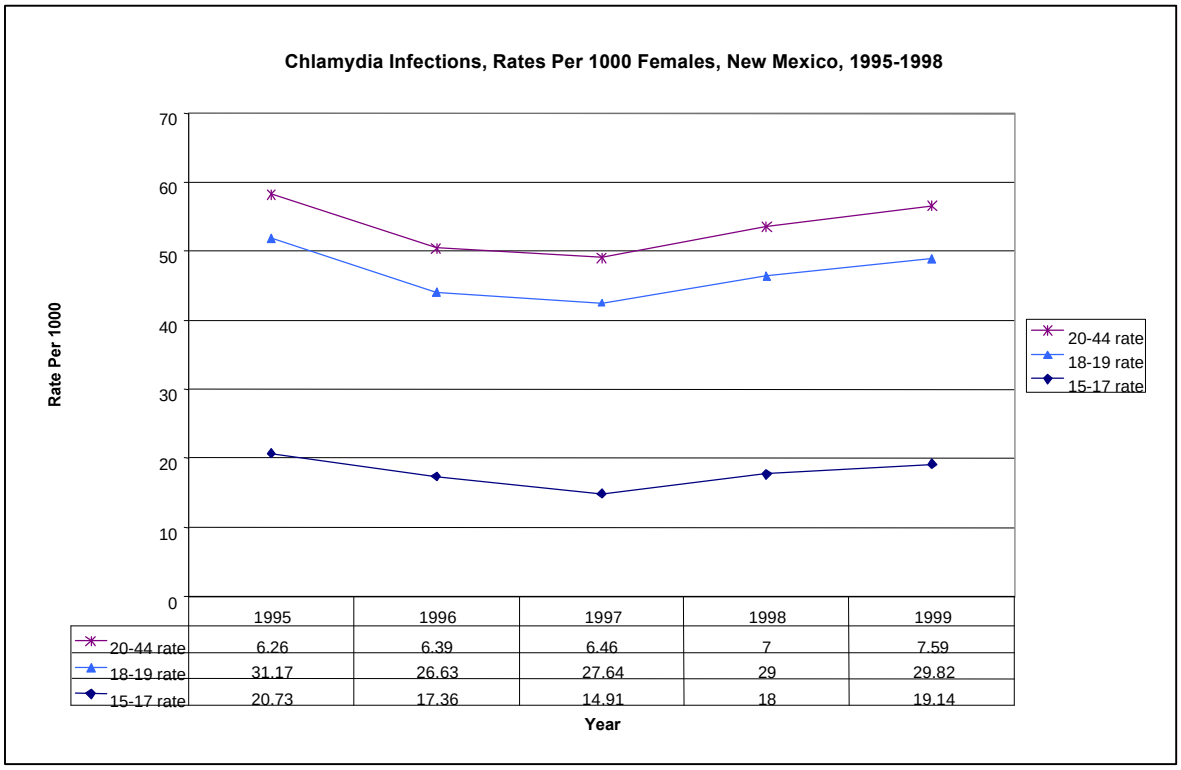


Table 1: Chlamydia infection rate per 1,000 population of females, New Mexico 1995-98

Year	(Age 15-17)	(Age 18-19)	Age 15-19	Age 20-44	Age 15-44
	Cases/Rate per 1,000	Cases/Rate per 1,000	Cases/Rate per 1,000	Cases/Rate per 1,000	Cases/Rate per 1,000
1995	825 cases 20.73	811 cases 31.17	1,636 cases 24.86	1,943 6.26	3,579 9.51
1996	713 cases 17.36	711 cases 26.63	1,424 cases 21.01	1,998 cases 6.39	3,422 cases 9.00
1997	632 cases 14.91	757 cases 27.64	1,389 cases 19.91	2,014 cases 6.46	3,403 cases 8.92
1998 [1]	397 cases 9.09	413 cases 14.71	810 cases 11.29	1,167 cases 3.80	1,977 cases 5.22
1999 [2]	836 cases 19.14	837 cases 29.82	1,673 cases 23.32	2,330 cases 7.59	4,003 cases 10.58

[1] Data errors for Chlamydia diagnosis were apparently made thus report based on average of 1997 and 1999 data. [2] Data for ages 15-17 and 18-19 cannot be retrieved through standard reports in the STD MMIS. Estimates based on allocating the half of the case numbers to each group. Population denominator for 1998 was used for 1999 estimates; 1999 intercensal est. not available.

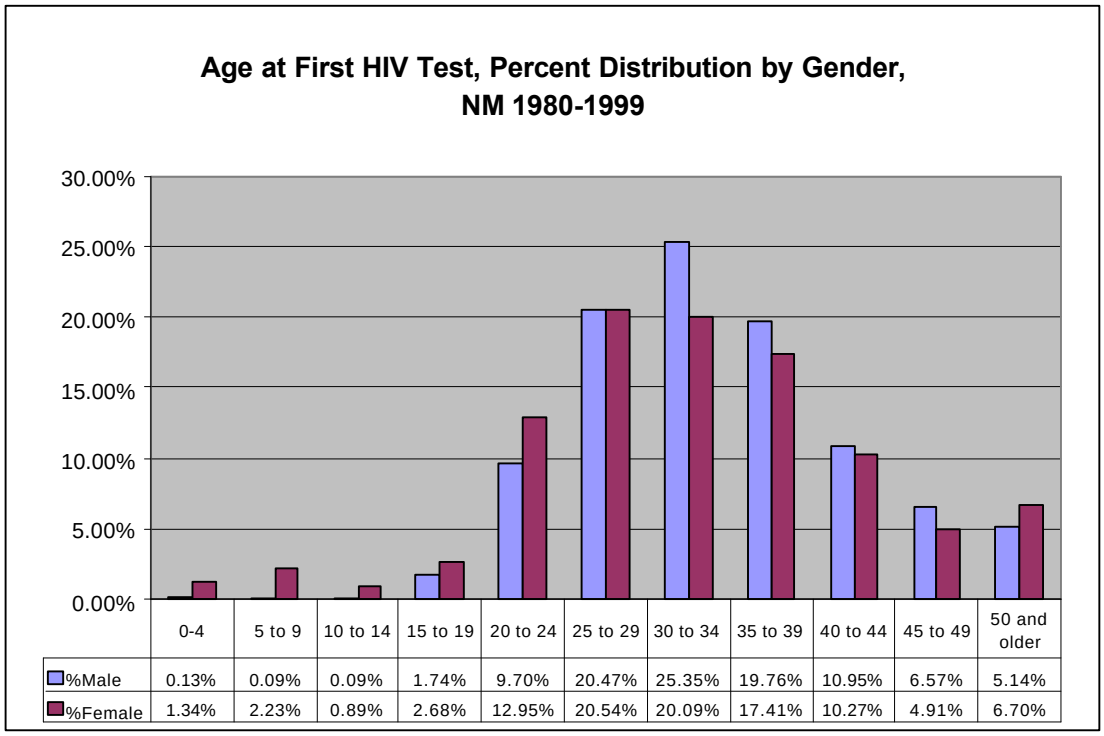
7. HIV Infection and AIDS: Between 1981 and April 30, 2000, there were a total of 1,932 cases of AIDS in New Mexico; 1,032 deaths for a case fatality rate of 53.4 per 100 cases. By race and ethnicity, 53% of cases were in whites; 36% in Hispanic whites; 6% in African Americans; 6% in Native Americans; and <1% in Asian/Pacific Islanders.

Perinatal HIV/AIDS: According to 1997-98 PRAMS, health care workers spoke to 52% of mother about how to prevent HIV infection and 75% of mothers about taking a test for HIV.

Pediatric AIDS <13 at Diagnosis: 14 cases for an estimated 0.215 cases/100,000 from 1980-2000.

8 cases (3 male and 5 female) infected because parent was at risk
5 male hemophiliacs infected through Coagulation Factor use
1 female case, recipient of blood or components of tissue

Figure 8: HIV Testing: Age and Gender New Mexico 1980-1999



	0-4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 and older
%Male	0.13%	0.09%	0.09%	1.74%	9.70%	20.47%	25.35%	19.76%	10.95%	6.57%	5.14%
%Female	1.34%	2.23%	0.89%	2.68%	12.95%	20.54%	20.09%	17.41%	10.27%	4.91%	6.70%

Adolescent and Adult AIDS Cases in Females: 204 cases for an estimated 1.25 cases/100,000 women age 15-44 from 1980-2000

12 infected by transfusion or blood products
23 manner of infection still undetermined
66 injection drug use
103 heterosexual contact with high risk person(s)

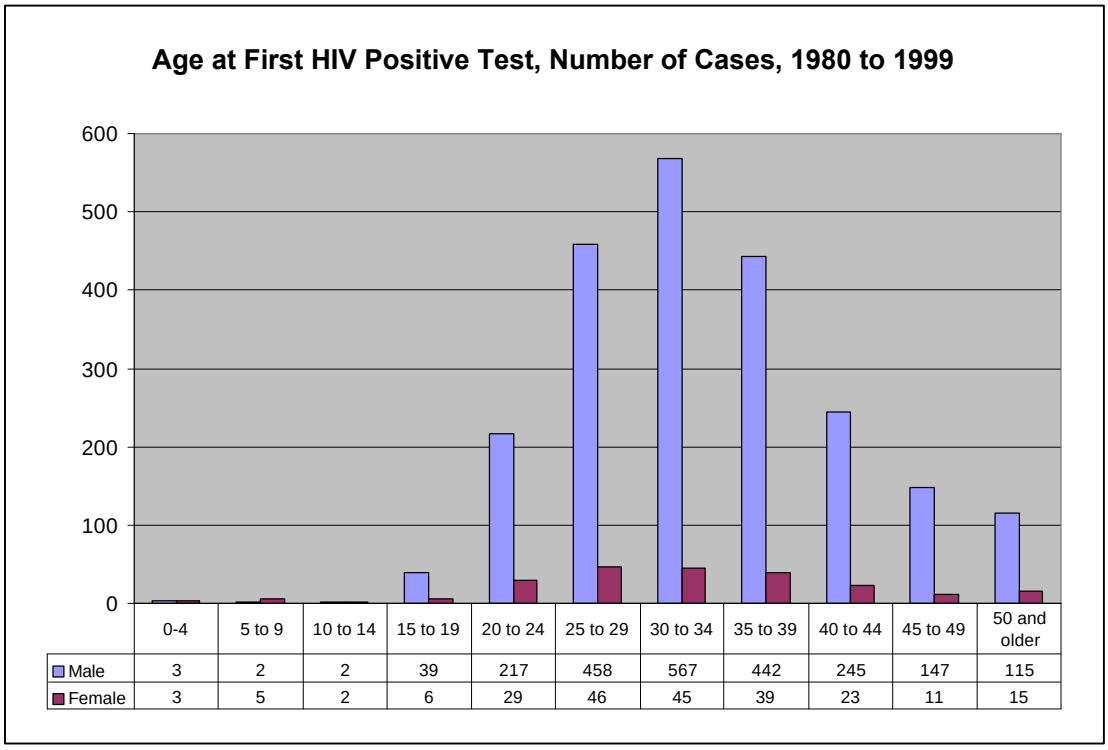
Adolescent and Adult AIDS Cases in Males: 2,295 cases

11 infected by transfusion or blood products
21 hemophiliacs infected through Coagulation Factor use
41 heterosexual contact with high risk person(s)

115 manner of infection still undetermined
187 injection drug use
232 injection drug use/male to male sexual contact
1,668 male to male sexual contact

Diagnoses in ages 20-24 imply infection in the teen years; cases through age 29 may have been infected during teen years.

Figure 9: Age at First HIV Diagnosis 1980-1999



	0-4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 and older
Male	3	2	2	39	217	458	567	442	245	147	115
Female	3	5	2	6	29	46	45	39	23	11	15

1999 YRBS, HIV Risks in Kids: New Mexico needs a relentless effort to educate and inspire youth to make decisions that will protect youth from AIDS. With 52% of youth in the state self-reporting that they had sex (29% at age 14 increasing to 67% at age 18) and 60% with more than one partner, the risk for HIV is present. Approximately one half (48.5%) reported using a condom and 20% didn't use a condom.

8. Pregnancy Morbidity: In 1995-96 the antepartum hospitalization ratio was 20.1 per 100 deliveries. This is in excess of the Healthy People goal of 15/100. The ratio for unduplicated women was 12.6/100 indicating repeat hospitalizations for about 30% of women. Higher hospitalization ratios were found for teens age 12-19 (25/100); Black mothers (42.3/100 although numbers were very small). The ratio for mothers on Medicaid (20.1) was not significantly different from those with private insurance (18.4); mothers who were indigent or had no source of payment but cash had a ratio of 10.9/100. The majority of hospitalizations were less than one day, 24/100; compared to 8/100 for 1 or for 2 days. Leading causes were preterm labor, Early Labor, Other Causes, Vomiting, and GU Infection. Mothers who had multiple

antepartum hospitalizations were more likely to be smokers (23.4%) than those with only one hospitalization (8%).[40]

Comparing NM PRAMS data to HIDD data, the majority of AP morbidity is treated on an outpatient basis in NM. Closer estimates of prevalence are seen in PRAMS data, albeit self reported: Diabetes in PRAMS 6.5% compared to HIDD 0.5%; Hypertension in PRAMS 8.9% compared to HIDD 1.3%; GU infection in PRAMS 14.7% compared to HIDD 1.4%.

Rates of Cesarean Delivery and Vaginal Birth after Previous Cesarean (VBAC), 1998: Given that a lower rate means better performance, for Cesarean Deliveries New Mexico ranked 4th in the nation at only 16.4% (US=21.0%). Similarly, NM ranked well for VBAC's with 35.2% compared to US rate of 26.3%.[41] The FY2001 update of this report will address cancer and chronic diseases in women in New Mexico.

9. Mortality In Women, Status, Trends And Disparities

Pregnancy related deaths result from

1) the complications of pregnancy itself;
2) the chain of events initiated by the pregnancy that led to death; or
3) aggravation of an unrelated condition by the physiologic or pharmacological effects of the pregnancy, that subsequently caused death within 365 days of pregnancy termination.[42]

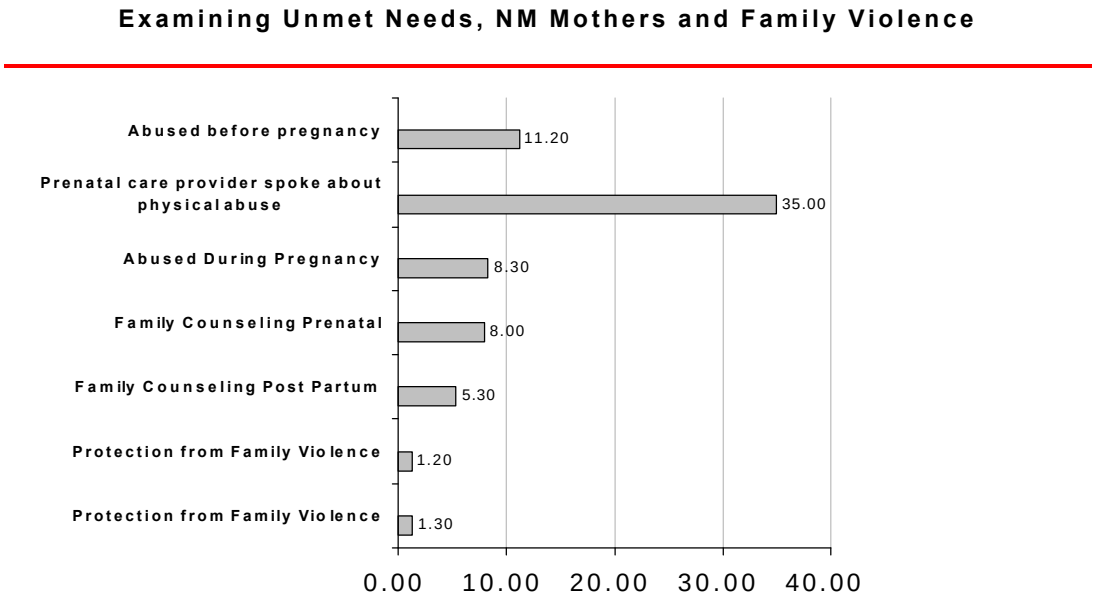
The official report of NM VRHS shows that between 1990 and 1997 there were a total of 27 maternal deaths, using a definition of pregnancy related and death within 42 days of the end of the pregnancy. Using Office of Medical Investigator files, the MMR team found 46 pregnancy-related deaths for that same period. However in this case, the numbers included some deaths within 365 days of the end of the pregnancy. The data will continue to be evaluated to reconcile definitions, date ranges and ICD ranges. Nevertheless, it does appear that the OMI files contain more complete information on maternal deaths than do the VRHS files. Using OMI data, between 1980 and 1999 there were 103 pregnancy related maternal deaths in 545,219 births yielding a rate of 18.9/100,000 births. The cause specific numbers and rates in rank order included: Hemorrhage 17 or 3.11/100,000 births; Embolism 17 or 3.11/100,000 births; PIH/Eclampsia 17 or 3.11/100,000 births; Infection 14 or 2.56/100,000 births; Cardiac 13 or 2.4/100,000 births.[43]

The New Mexico Maternal Mortality Review (MMR) team reviews the deaths of all women who were pregnancy and/or ended the pregnancy within 365 days of the death. For the period 1990-1999, using OMI files and excluding pregnancy related deaths, there were 72 such deaths for a rate of 26.33 deaths per 100,000 live births. These deaths were largely intentional or unintentional injuries and included motor vehicle injuries, homicides, suicides and other injuries. These rates are similar to injury rates reported for the general female population by NM Vital Statistics, i.e. 1995-1997 accidents at 26.3/100,000 women age 25-44. Nevertheless, these findings do signify the need for injury and violence prevention screening and counseling for women in pregnancy.

Intimate Partner Violence: Intimate partner violence (IPV) is a major public health problem in New Mexico. In 1996, adults age 18 and older self-reported lifetime prevalence of emotional abuse of 32% and physical abuse of 17%.[44] In the first nine months of 1999, 21,180 incidents of domestic violence were reported by 69 out of 133 law enforcement agencies.[45] These reports represent about half of reports; they are not unduplicated individuals and include abuse between household members not just intimate partners. 36% of the incidents involved a weapon and 30% involved alcohol or drug use by either/both the assailant and the victim. Between 1993-96, there were 129 homicides of females; 46 or 35% were involved with an intimate partner. The age ranged from 17 to 80 with an average age of 37. Nearly 2/3 were Hispanic; 26% non-Hispanic white; and 11% were Indian. Of male perpetrators, the ethnicity was unknown in 33% of deaths. Of known ethnicity, the men were 30% Hispanic; 24% Anglo; 7% American Indian and 7% African American. Only 8 of these women had a legal order of protection. In half of these deaths, children were present at the time of the homicide.[46] In Albuquerque, 11,865 domestic violence incidents were reported in 1999. Of these, 49% involved a weapon; 27% involved drugs or alcohol; 25% involved injury. Domestic violence is Albuquerque's number one reported misdemeanor crime.[47] This special report spurs a program to prevent Intimate Partner Violence (IPV) in the Injury Prevention Bureau with a high degree of collaboration with the Family Planning Program in the FHB. Intimate Partner Violence is a major public health problem effecting women in New Mexico:

- 90% of victims reported by law enforcement agencies in the first half of 1999 were women
- 33% of female patients seen in NM Emergency Rooms are there because of domestic violence
- 36% of 129 female homicides between 1993-96 involved a current or former intimate partner[48]

Figure 10: Summary of NM Mothers Experience with Abuse and Getting Services

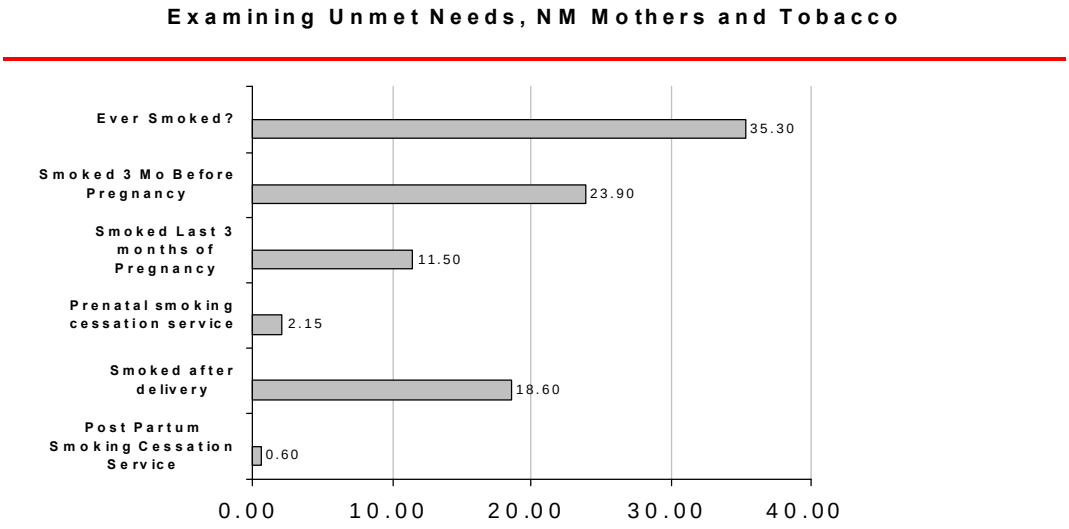


NM PRAMS, 1997-98

10. Smoking Before, During And After Pregnancy

Tobacco use is a serious problem among women in New Mexico. Nearly a quarter smoked in the preconceptional period. Given the serious addictive nature of smoking tobacco, it is not surprising that only a portion quit in pregnancy and that almost all resume smoking postpartum. The state has virtually no services for smoking cessation in women who are pregnant.

Figure 11: Unmet Needs In Pregnancy

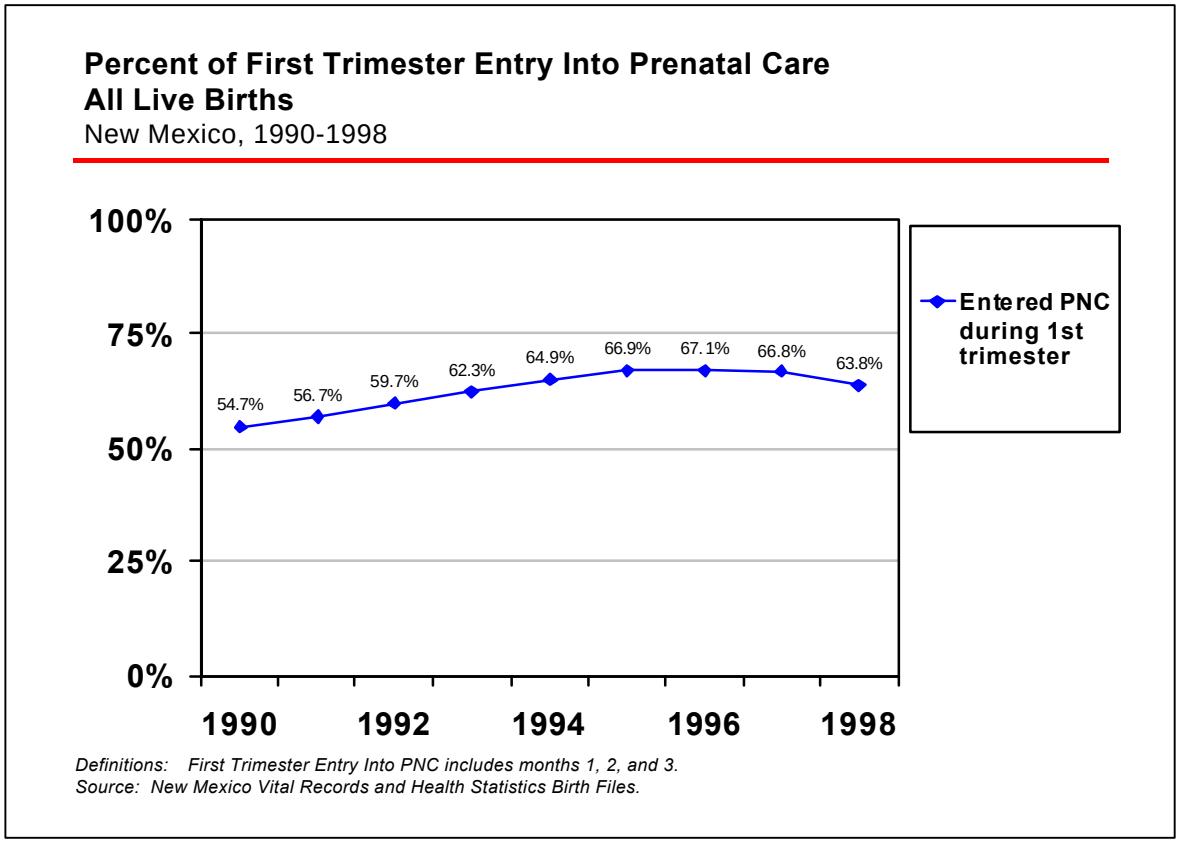


NM PRAMS, 1997-98

11. Access To and Use Of Prenatal Care

Prenatal Care Access and Utilization: New Mexico mothers rank 50th in the nation for entry into first trimester prenatal care in 1997 and 1998. There was a steady increase from 54.7% in 1990 to 66.8% in 1997. Increases between 1990-1993 are associated with the change in Medicaid eligibility from 135% to 185% of poverty, effective July 1991. The outreach efforts to get women enrolled earlier took about one year to show an effect. Ratio's continued until in 1998 First Trimester Prenatal Care dropped to 63.5% with more severe drops reported in Health District I (65% to 60.7%). Other Districts dropped 1-2 percentage points.[49] The County and Health District performance for this indicator is found at the end of this section. The declines in 1st trimester Care are associated with the shift to Medicaid Managed Care in July 1998 as well as other key factors. Some areas reported having no prenatal care provider although they had a federally qualified health center with physicians and mid-level practitioners. The cost of malpractice insurance is apparently prohibitive for the small rural areas that were so affected.

Figure 12: First Trimester Prenatal Care



Women more likely to **not** receive 1st trimester care are:

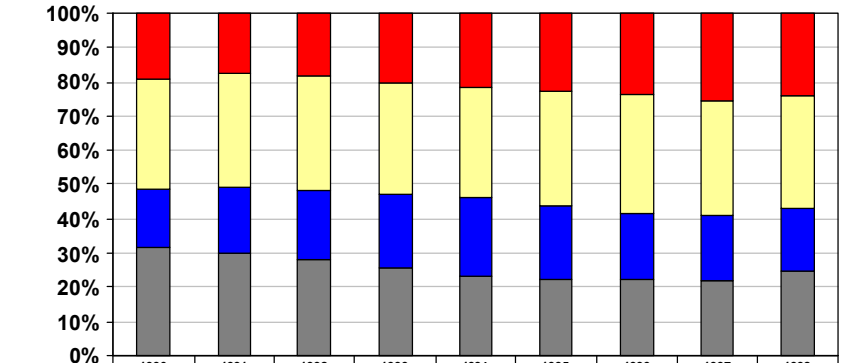
- ✓ Age 15-17 = 63%; Age 18-19 = 44.9%;
- ✓ Black = 47.5%; Native American = 34.6%; Hispanic White = 33.6%;
- ✓ Less than High School Education = 41.5% (includes teens);
- ✓ Not married = 43.3%
- ✓ At or below poverty line ~42%; On Medicaid = 36.8%
- ✓ Lived in PHD District IV = 32.3%
- ✓ Had a previous live birth = 32%

Women more likely to not receive any prenatal care were similar to those who did not get care in the 1st trimester. The risk of infant mortality is associated with prenatal care. Between 1995-97, the overall infant mortality rate (IMR) was 6.28; for the 1,597 women receiving no prenatal care the IMR was over 3 times greater at 15.03. The IMR for white mothers was 13.98 (18/1,288 births with no prenatal care) and for American Indian Mothers was 23.35 (6/257 births). Where prenatal care entry was unknown or not stated for 3,295 women, the IMR was over 3 times greater at 22.15.[50]

Adequacy of Prenatal Care Index (Kottlechuck): This is a new measure for use in New Mexico. Since 1990, the proportion of mothers receiving adequate or adequate plus care increased gradually from 51.3% in 1990 to 58.8% in 1997, and dropped slightly to 56.8% in 1998. The United States rate in 1997 was 75%.

Figure 13: Adequacy of Prenatal Care, New Mexico 1990-1998

Adequacy of Initiation of Prenatal Care:
Percent Distribution:
Final Kotelchuck Construct (INDEXSUM)
New Mexico, 1990-1998



	1990	1991	1992	1993	1994	1995	1996	1997	1998
AdequatePlus	19.4%	17.4%	18.0%	20.0%	21.6%	22.8%	24.0%	25.3%	24.2%
Adequate	31.9%	33.2%	33.5%	32.9%	32.3%	33.3%	34.3%	33.5%	32.6%
Intermediate	17.3%	19.5%	20.2%	21.5%	22.9%	21.4%	19.2%	19.3%	18.5%
Inadequate	31.4%	29.9%	28.3%	25.7%	23.2%	22.4%	22.5%	21.9%	24.7%

Definitions: First Trimester Entry Into PNC includes months 1, 2, and 3.
Source: New Mexico Vital Records and Health Statistics Birth Files.

Predictors of Adequacy of Prenatal Care: In 1997-98, women who were more likely to not receive an adequate level of prenatal care (Kottlechuck) were those with an unintended pregnancy; women who did not recognize they were pregnant in the 1st trimester.[51] The overall state average for inadequate care was 29.5%. Multivariate analysis of the VRHS and PRAMS data revealed those with higher proportions of inadequate care to be: teen mothers 15-17 (63%) and 18-19 (45%); at or below Federal Poverty Line (42%); Medicaid eligible mothers (37%); Native American mothers (35%); and mothers with a previous live birth (32%).

12. Access To And Use Of Health Related Services During And After Pregnancy

Access to and Use of WIC Nutrition Services: Between 1998-99, the WIC program served a monthly average of 6,722 pregnant women; 2,681 breastfeeding women; 3,210 postpartum women; 13,145 infants <1 year; and 27,417 children age 1-5 years. In 1999, there were 92,588 potential eligibles, however data for 1999 clients served is not yet available.

The Families FIRST Case Management program: is described in Section 1.5.1.2 Program Capacity. In the last half of FY1999 (1/1/1999-6/30/1999), a total of 2,377 mothers and 2,393 children were served. An average of 396 mothers and 398 infants were served per month. Although <20% of births are to teens, in Families FIRST 32% of mothers served were teens and 68% were age 20 or older. This distribution was similar across all four Health Districts and reflects outreach to this higher risk group. Of children served, 73% were 0-3 months of age; 23% were 4-11 months; and 3% were between 1-2 years of age.

Table 2: Families FIRST Services to Mothers and Children, Age at Service

FY2000	Services to Mothers Jul-Dec 1999			Services to Infants and Toddlers Jul-Dec 1999			
	% clients <20 Years	% clients >20 Years	Total Number	% clients 0-3 months	% clients 4-11 months	% clients 1-2 Years	Total Number
I	33%	67%	867	69%	30%	1%	1,008
II	37%	63%	313	88%	10%	2%	399
III	33%	67%	516	70%	22%	8%	580
IV				77%	20%	3%	406
All	34%	66%	1,696	73.5%	23%	3.5%	2,393

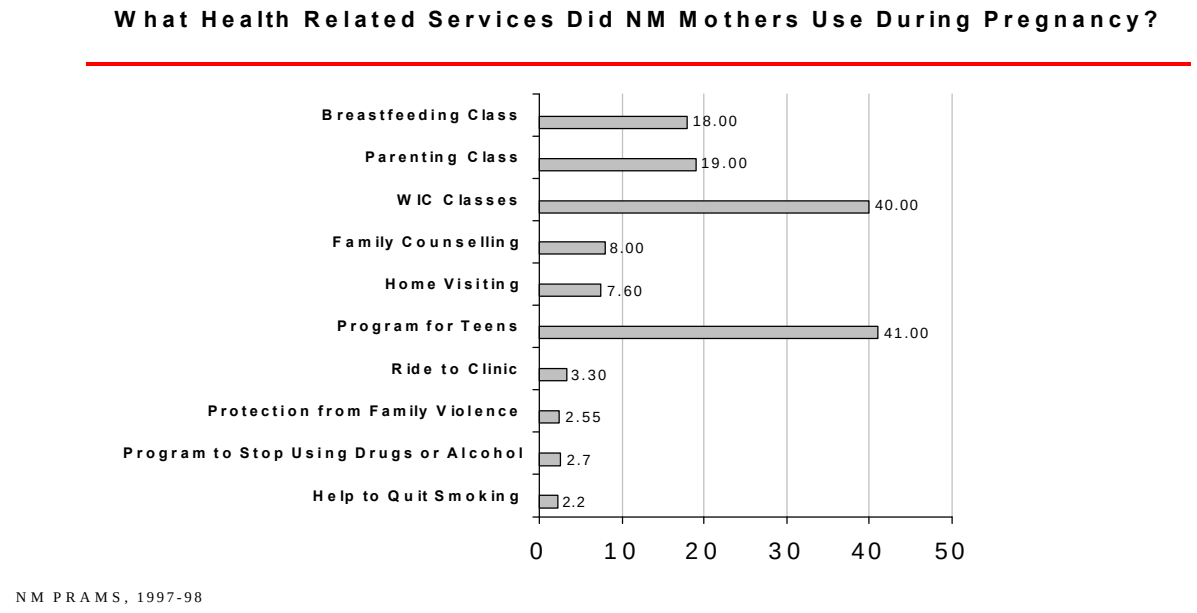
In FY1999 (7/1/1998-6/30/1999) Families FIRST served a total of 3,129 mothers and 3,582 children; an average 260 mothers and 298 infants per month

Table 3: Families FIRST Services to Mothers and Children in 1998, Age at Service

FY1999	**Services to Mothers Jul 98-Jun 99**			**Services to Infants and Toddlers Jul 98 - Jun 99**			
Districts	% clients <20 Years	% clients >20 Years	Total Number	% clients 0-3 months	% clients 4-11 months	% clients 1-2 Years	Total Number
I	31%	69%	1,052	74%	22%	3%	1181
II	33%	67%	633	75%	23%	2%	729
III	31%	69%	590	78%	20%	1%	931
IV	34%	66%	854	82%	18%	0%	741
All	32%	68%	3129	77%	21%	2%	3,582

The following chart shows that the services most frequently used by women during pregnancy were WIC classes and programs for teens (used by 40 and 41 percent of mothers respectively). Following delivery, the most frequently used services were, in order, WIC classes (34.10%), programs for teens (14%), and home visiting services (12%).

Figure 14: Utilization of Health Care Services in Pregnancy



The highest level of need for health related services in New Mexico is:

- Smoking cessation services are virtually non-existent for pregnant and postpartum women.
- Alcohol prevention and treatment services, with only one center at UNM in Albuquerque
- Drug prevention and treatment services, with only one center CAASA of UNM in Albuquerque
- Increased providers to help women with family violence and other psycho-social problems
- Improved access to transportation services for those in need.[52]

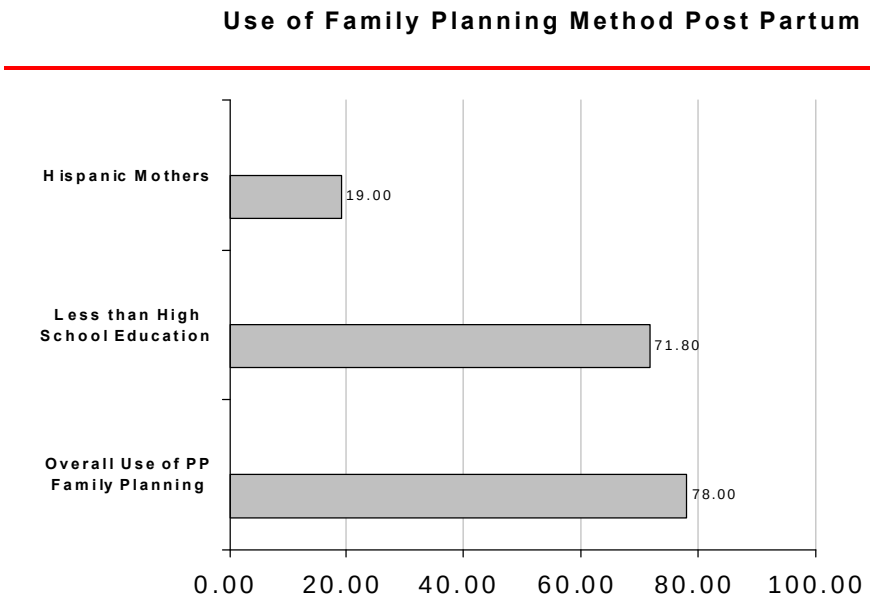
Table 4 illustrates access and usage of services during pregnancy and in the postpartum period.

Table 4: Access to and Use of Pregnancy and Postpartum Related Health Services:

Type of Service	During Pregnancy	Post Partum	Comments and Indications of Unmet Need
Breast Feeding Class	18.27	8.4	87% said a health care worker spoke to them about breast-feeding in PNC.[1] 72% initiate breast feeding; 58% continue for at least 1 month; 49% continue for 2 months; longer continuation is not reported by NM PRAMS
Parenting class	18.65	3.84	These proportions are very low considering the need for parenting support.
WIC classes	40.12	34.6	This estimate shows how many women were on WIC before and after pregnancy.
Counseling for family problems	8.05	5.3	There is a need for family counseling services in all counties.
Home visiting	7.61	12.48	Home visits for first time mothers: 9.3% in prenatal period; 16.7% within 2-6 months of delivery
Service for pregnant teens	41%	14%	The school-based programs are effective in helping teens finish school and avoid a second pregnancy before finishing high school.
Transportation	3.27	1.67	Transportation was infrequently mentioned as a barrier to prenatal care.
Protection from family violence	2.55	1.33	Only 35% said a health care worker spoke to them about physical abuse; with 11% abused before pregnancy and 8.3% during pregnancy; of women at or below FPL ~30% report abuse.
Program to stop using drugs or alcohol	2.67	1.0	82.5% said a health care worker spoke to them about how alcohol could affect their baby 44% used alcohol before pregnancy; 4% said they used alcohol in last 3 months of pregnancy 76.6% said a health care worker spoke to them about how use of illegal drugs could affect their baby;
Program to stop smoking	2.15	0.6	83% said a health care worker spoke to them about smoking During pregnancy ~ 201 or 2.6 smoked the same or more; 366 or 8.4% reduced the amount they smoked; and ~4,860 smokers or 12.8% quit; After delivery an estimated 18.6 mothers reported smoking; ~3,760 or 9.8% of prenatal smokers continued to smoke; only ~370 or 1% quit and stayed quit; 0.5% reduced the amount of smoking.
Postpartum Birth Control		78.0	84% said a health care worker spoke to them about post partum birth control; 78% reported using a family planning method after delivery; this was lower for Hispanic mothers (19%) and those with less than a high school education (71.8%).

[1] PNC= Prenatal Care

Figure 15: Family Planning Methods

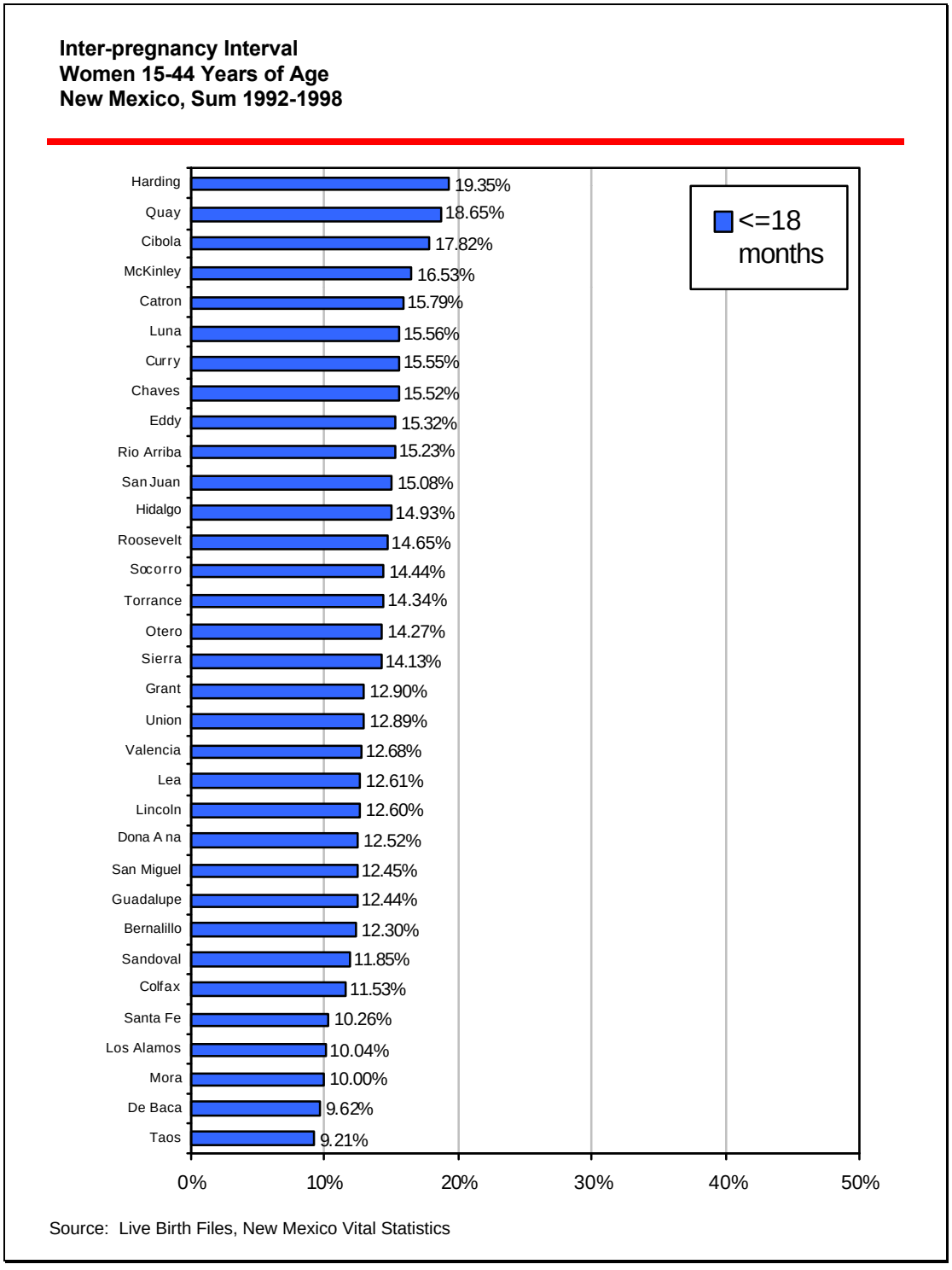


13. County And District Level Comparisons, Women's Health Indicators

The following section presents comparisons of women's health indicators for the 33 New Mexico Counties and 4 health districts. In sparsely populated Harding and Quay counties, almost one fifth (20%) of births had interpregancy intervals of 18 months or less. The interpregnancy interval has declined in the past decade in all but one of the past nine years. District 4 in southeastern New Mexico has the highest percentage of short intervals between births.

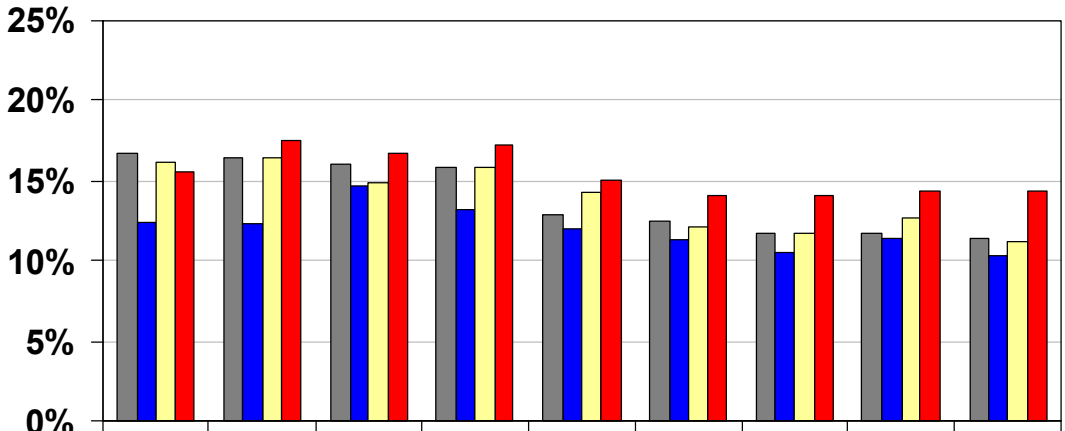
In six counties, more than 70% of women begin prenatal care in the first trimester; these counties include Union, Los Alamos, Colfax, Chaves, Sierra, and Harding. In Luna and McKinley County, less than 50% of mothers enter into prenatal care in the first three months. In all districts since 1995, the percentage of mothers entering prenatal care in the first trimester has exceeded 65%.

Figure 16 et al: Inter-pregnancy Intervals, PNC Entry



Inter-Pregnancy Interval (<=18 Months) Among 15-44 Year Olds Among 15-44 Year Olds with Current Singleton Birth Percent Breakdown by Public Health Districts

New Mexico, 1990-1998



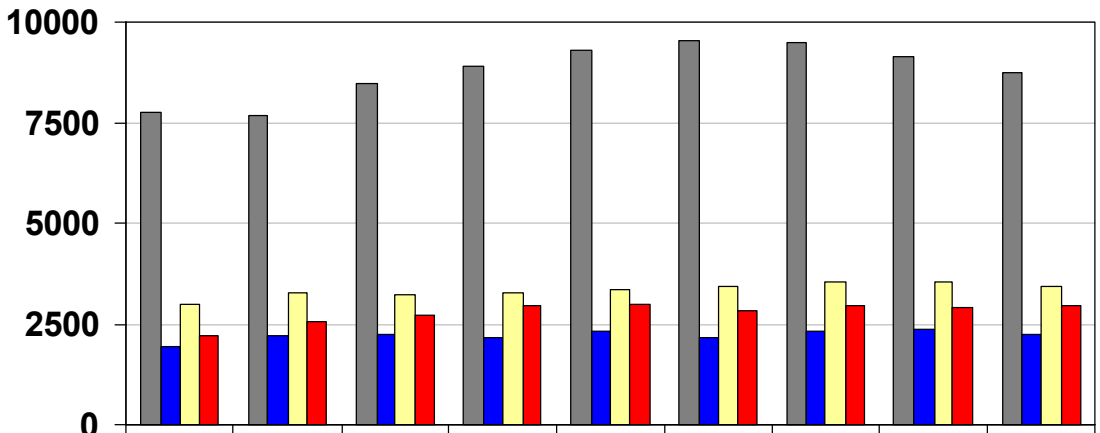
	1990	1991	1992	1993	1994	1995	1996	1997	1998
District 1	16.72%	16.44%	16.06%	15.82%	12.92%	12.52%	11.79%	11.64%	11.39%
District 2	12.43%	12.31%	14.64%	13.20%	12.03%	11.37%	10.53%	11.39%	10.34%
District 3	16.16%	16.50%	14.90%	15.85%	14.22%	12.05%	11.66%	12.70%	11.16%
District 4	15.55%	17.55%	16.69%	17.21%	15.06%	14.11%	14.06%	14.36%	14.39%

Definitions: Inter-pregnancy interval is a dichotomized variable. It quantifies the percent of women age 15-44 with a repeat pregnancy (present live birth);
Singleton births excludes twins and triplets among present live birth.

Source: New Mexico Vital Records and Health Statistics Birth Files.

First Trimester Entry Into Prenatal Care
All Live Births
Breakdown by Public Health Districts

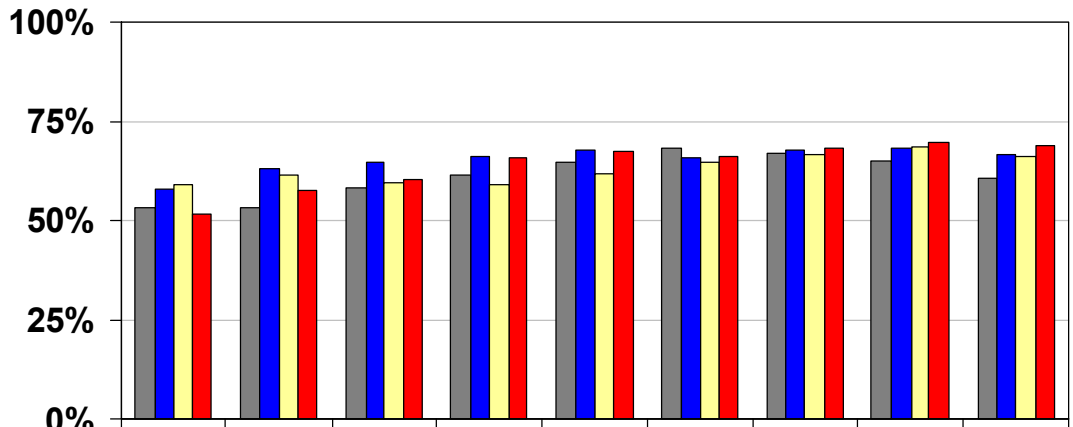
New Mexico, 1990-1998



	1990	1991	1992	1993	1994	1995	1996	1997	1998
District 1	7736	7677	8455	8917	9257	9541	9463	9128	8742
District 2	1970	2210	2255	2181	2312	2201	2314	2345	2259
District 3	2973	3285	3226	3293	3344	3435	3538	3559	3455
District 4	2234	2586	2720	2953	2980	2834	2949	2900	2955

Definitions: First Trimester Entry Into PNC includes months 1, 2, and 3.
Source: New Mexico Vital Records and Health Statistics Birth Files.

Percent of First Trimester Entry Into Prenatal Care
All Live Births
Breakdown by Public Health Districts
New Mexico, 1990-1998



	1990	1991	1992	1993	1994	1995	1996	1997	1998
District 1	53.2%	53.4%	58.3%	61.7%	64.7%	68.2%	67.0%	65.0%	60.70%
District 2	57.8%	63.0%	64.5%	66.1%	67.5%	66.0%	67.7%	68.1%	66.60%
District 3	59.0%	61.1%	59.7%	58.9%	61.8%	64.6%	66.5%	68.5%	66.10%
District 4	51.6%	57.3%	60.2%	65.8%	67.2%	66.2%	68.0%	69.6%	69.00%

Definitions: First Trimester Entry Into PNC includes months 1, 2, and 3.
Source: New Mexico Vital Records and Health Statistics Birth Files.

B. Health of Infants, Toddlers and Children from Birth to Age 9

Statewide Needs Assessment Provided Local Perspectives on Health Issues for Children 0-9 Years: District and local MCH program staff provided important insights into issues for this age group. Since the early 1980's, the Public Health Division's local health offices discontinued the majority of its well childcare services. As a result, staff are more often concerned with access to care issues and finding services for those who have no resources. The following was identified as important:

Health Status Problems (morbidity, mortality, injury, disability):

- Asthma-how environmental health affects children
- Diabetes and obesity in children.
- Incidence of suicide, gang violence and safety /injury issues.
- Sequelae of low birth weight
- Early dental problems and infant baby-bottle tooth decay
- Infectious diseases, pockets of low immunization rates
- Poor nutrition, low levels of physical fitness and obesity in young children
- Access to family firearms
- Use of alcohol, substance and tobacco in the family
- Parenting problems associated with low income, single parenthood, teen parenting

Healthy and Health Risk Behaviors in the Family

- Guns access and use by young people.

Lack of Health Services (clinics, providers, specific services)

- Number of providers; lack of Medicaid providers, overburdened providers:
  - ✓ McKinley Co. has no dental providers who accept Medicaid; pediatric dentist needed
  - ✓ Dental services in Roswell, especially for Medicaid patients. "There are clinics in the district but more in Roswell. Clients don't have the transportation to go to Portales, Fort summer, etc."
  - ✓ Limited Specialist –only three pediatricians in Carlsbad; Artesia has no specialty services; Dental services are extremely limited
- Vision and hearing screening hard to access.
- Dental: extent of unmet needs and baby bottle tooth decay
- Mental health needs/counseling for preteens and teens
- Substance Abuse Treatment Centers for all ages
- Preventive services in elementary school to increase self esteem
- Services for immigrants, undocumented population.
- Lack of prenatal care/ local hospital for delivery, lack of OB-GYNS.
- Demand issues: poor recruitment incentives resulting in limited number and high turnover of providers, and increased vacancies

Lack of Support Services (Health Related, Social, Child Care)

- Childcare providers located in Gallup are not accessible to 72% of the population
- Lack of quality day care at a reasonable cost.
- Employers not supporting breastfeeding lack work place policy, place to breastfeed, and flex time).

What Children and Families Need

Basic Needs:
-Food
-Water
-Sleep
-Clothing
-Shelter
-Safety
-Predictability
-Healthy Air
-A Sense of Values
Risk Factors: Basic needs not met according to minimal standards

Parenting Resources:
-Information
-Support
-Income/Employment
-Personal Needs Are Met
-Intergenerational Support
-Elder Care
-Domestic Violence Shelters
-Early Childhood Programs
-Access to Resources
-Empowerment
Measures: Income Disparities; Unemployment; Access to Home Visiting; Access to Mental Health Services; WIC Participation

Nurturing:
-Parent-Child Relationships
-Early Experiences
Breastfeeding
Bonding
Parent-Infant Interactions
-Self-efficacy
-A Sense of Being Valued
-Mentoring

Health and Health Related Services:
-Physical and Mental Health
-Nutrition and Dental Services
-Immunizations
-Substance Abuse Treatment
-Translation Services
-Transportation Services
-Respite Services
Measures: Access and Utilization; Morbidity Mortality; Health Status
Risk Factors: Barriers of Language, Citizenship or Geography; Lacks of Providers or Reimbursement (Including Transportation); Insufficient Strategies to Assure Access; Untrained Providers; Clients Are Not Able to Access the Systems; Services Are Not Available for Special Needs

Children & Families
(0-3) (4-9yrs)
Sociodemographics:
Population, age, ethnicity, income, education, legal status,
Ability to read
Special Needs: Physical Emotional; Developmental

Places Where Needs Are Met And Influences on Ability to Meet Needs

Family

Family Lifestyle:
-Assets
Eating Patterns
-Physical Activity
-Culture
-World View
-Modeled Values
-Spirituality
-Shared Belief System
-Religious Affiliation
-Relationships
-Family History
-What children learn overtly and covertly
-Responsibility
-Discipline
-Communication
-Spending TimeTogether
- Entertainment/ Use of Media

Risk Factors: Parents Not Available; Sense of Hopelessness; Substance Abuse; Firearms Physical and Emotional Abuse; Family Member in Prison

Measures: Intentional and Unintentional Injury; Suicide; Domestic Violence; Abuse or Neglect

(Pre-)School

-Peers
-Support Groups
-Communication
-Family Partnership
-Health Services
-Community Partnership
-Conflict Resolution
-Critical Thinking
-Problem Solving
-Extracurricular Activities
-Preparing Children for Success
-Transportation
-Culture
-Relationship to Families
-Resource Centers
-Support for Diversity

Risk Factor: Lack of Positive Relationships With Families and Community

Measures: School Performance
Attendance
Test Scores

Community

-Group Acceptance
-Recognition and Planning for Developmental Needs
-Transportation
-Opportunities for Group and Extended Family Activities
-Relationships and Resources
-Support for Diversity
-Inclusion for Special Needs
-Child Care
-Formal and Informal
-Foster Care
-Other Caring Adults
-Important Mentors
-Spiritual Leaders
-Opportunities For Success

Risk Factors: Hate Crimes; Racism Parenting and Children Not Valued;

Children Marginalized or Stigmatized;
Lack of Quality Child Care and Foster Care

Measures-Quality/Availability/Affordability

Lack of Support Services (Health Related, Social, Child Care) *continued*

- Lack of Medicaid payment for direct nutrition services.
- Support Groups: parenting classes and support groups for parents with behaviorally difficult children (ADHD children); unattended children whose parents or caretakers are in treatment centers or incarcerated.
- Need for support services, distance and transportation constraints, no access to residential treatment (hospitalization for psychiatric services), limited stay; out of town placements, and not allowing for family treatment while under care and no access to respite care for families with severe emotionally disturbed children; no access to sex-offending treatment

Issues Specific to School Health

- Health education curriculum needs to be based on what is needed
- Very little focus on elementary school. Preventive efforts could be more effective if a younger age was addressed. Need collaborative focus or younger ages and a good model to do this.
- Safe date education, sexual education and prevention
- Transition services to public schools 0-3 to 3-4

Need Community Based System of Care

- Coordination needed among school districts, coordination for assessment and planning among DOH and community groups; developmental delays and early detection.
- Coordination issues and a greater need to prioritize because of limited resources. Inflexibility of programs because of funding constraints and continuity of care issues. Confidentiality presents a barrier to share information between agencies. Need for agencies to work more closely together
- Medicaid kids not receiving immunizations at MCO's per focus groups.
- Better primary care follow-up on referrals.
- Weak relationship between medical and dental community toward Salud!

Barriers to Health Services

- Access to health care in outlying counties, transportation, no public transportation available in the city limits of Gallup, transport is limited to paved roads only in the county (Navajo Nation Transit, Safe Ride, ZEE Transportation).
- Issues relevant to reaching the undocumented youth population need to be sensitively addressed so this population can easily access services and benefit from care. There is a need to establish a process/ forum for youth so that their voice is heard and their input taken into planning strategies. One participant mentioned the concern that parents are not "available" because of long working hours and the negative implications it has on children.
- Providers do not have a holistic approach with moms, " "tunnel vision".
- Lack of information, identify early EPSDT services for all children

Quality of Care Issues

- Lack of support and attention given to people who need assistance in completing the required forms to receive care.
- Need to treat children in the context of family and to conduct early assessments of the family situation and a better system for getting women and children enrolled in health insurance plans.
- Provider communication skills: Many service providers don't take the time to inform CSHCN and their families about ancillary services provided by early intervention providers.
- Quality of Care issues linked to inadequate staffing and patient overload. Continue to lose providers; lack of early intervention providers and providers who support breast feeding

As with all other population-based assessment groups, the issues of access to and use of health and health related services was the leading concern. See more on this in the section on Direct and Enabling Services.

1. Socio-Demographic and Economic Overview:

In 1997-98, there was an estimated 273,350 children age 0-9 years in New Mexico.[53] Over half of this population are Hispanic, American Indian or African American. More than 2/3 of this group lives in metropolitan or urban areas. There are no estimates of the undocumented population in this age group. Often the infants or toddlers were born in the United States while parents may be undocumented. This presents an important gap to basic services such as WIC or Medicaid as parents who may fear being found out by immigration authorities may not seek needed health care services.

Poverty: 29% under age 5 and age 5-17 live at or below the Federal Poverty Line (FPL).[54]

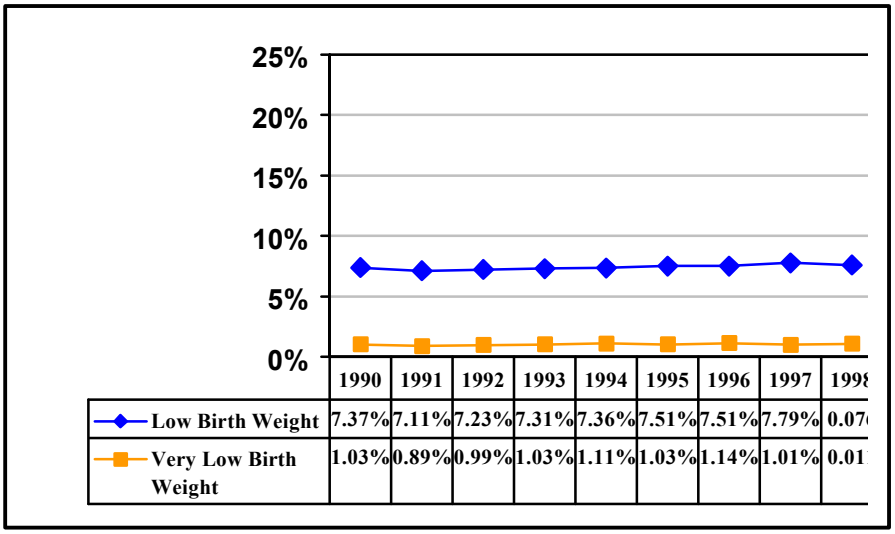
Health Insurance: 20.7% had no health insurance compared to 14.8% nationally.

Family Characteristics: Social determinants of health are significant. The health of infants, toddlers and young children is an indicator of the health of society. It is also a key concern as health policy leaders work with issues of family strengths and needs.

2. Infants At Birth: Status, Trend And Disparities

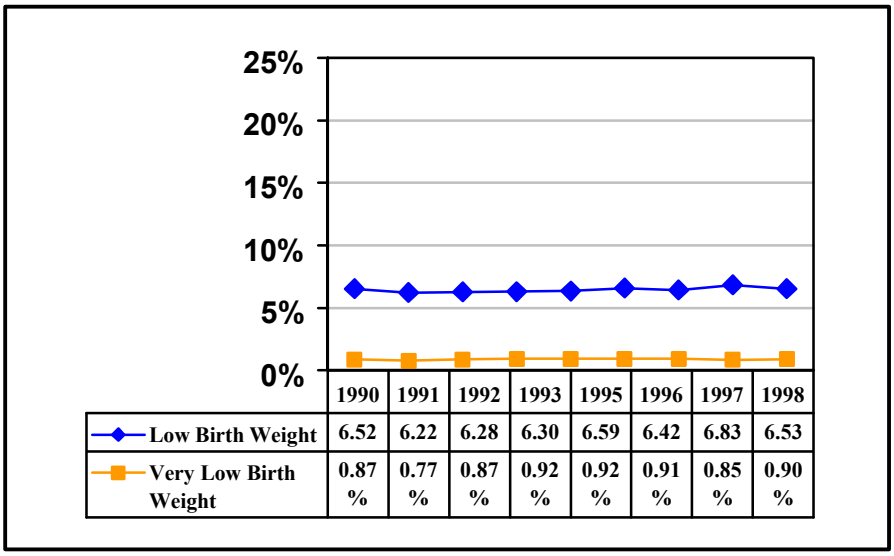
Low Birth Weight: Since 1990, an average 7.4% (range 7.1-7.8%) of infants were low birth weight (LBW) at birth; a total of 2,042 infants in 1998. During the same period, an average 6.5% of singleton births were LBW; a total of 1,719 infants in 1998.[55] In 1998, with a ranking of 7.6%, New Mexico ranked 28th in the nation for this indicator (US = 7.6%).[56]
Very Low Birth Weight: Since 1990, an average 1.03% (range .089-1.11%) were very low birth weight (VLBW) at birth; 293 infants in 1998. During the same period, an average 0.9% of singleton births were VLBW; 237 infants in 1998. In 1998,with a ranking of 1.1%, New Mexico ranked 8th in the nation with 42 states having a higher rate (US = 1.4%). The rate of preterm birth has not changed in 40 years and remains the leading cause of neonatal and postneonatal mortality and morbidity; the greatest burden on infants born <750 grams.

Figure 1: Low Birth Weight and Very Low Birth Weight in New Mexico, 1990-98



	1990	1991	1992	1993	1994	1995	1996	1997	1998
Low Birth Weight	7.37%	7.11%	7.23%	7.31%	7.36%	7.51%	7.51%	7.79%	0.07
Very Low Birth Weight	1.03%	0.89%	0.99%	1.03%	1.11%	1.03%	1.14%	1.01%	0.01

Figure 2: Low Birth Weight and Very Low Birth Weight Among Singleton Births



	1990	1991	1992	1993	1995	1996	1997	1998
Low Birth Weight	6.52	6.22	6.28	6.30	6.59	6.42	6.83	6.53
Very Low Birth Weight	0.87 %	0.77 %	0.87 %	0.92 %	0.92 %	0.91 %	0.85 %	0.90 %

High proportions of VLBW survivors suffer from chronic disabilities. Of survivors born between 1993-96, 85 or 82% were evaluated through the University of New Mexico follow-up study at 18-22 corrected months. Results included (N=85):

- Neuromotor abnormality in 24 or 28%
- Cerebral palsy in 16 or 19% with 10 quadriplegics; 3 hemiplegics; 1 diplegia ; 2 global hypotonia
- Other neuromotor abnormalities seen in 8 or 9%
- Visual impairment affected 18 (21%)
- Normal outcome noted for 18 or 21%
- Major disability noted for 42 or 49%
- Multiple disabilities noted for 19 or 22%

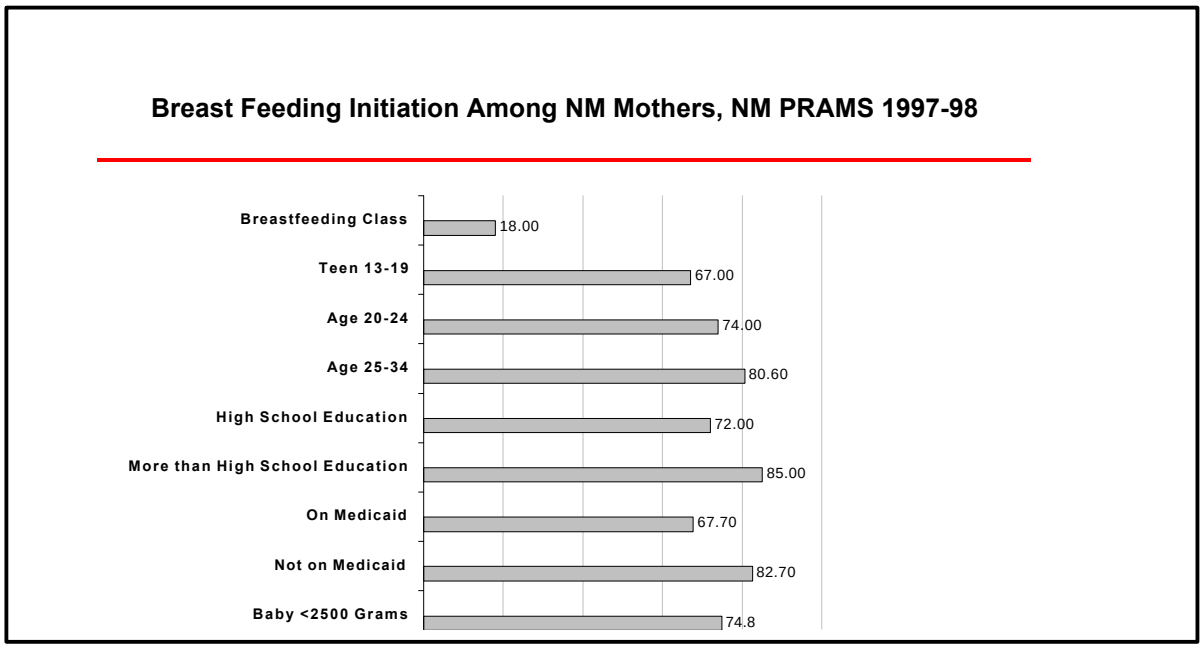
For infants who were Extra Low Birth Weight (ELBW) <750 grams: health status was lower than controls; both parents and professional care givers reported the ELBW infants had a lower quality of life with most living with long term sequelae. Survival was highly dependent on delivery at perinatal center with the pre-labor use of corticosteroids to hasten lung development.[57]

3. Nutrition Of Infants, Toddlers And Children

a. Breast Feeding Initiation and Continuation: Breast-feeding has known benefits for physical and emotional health of mothers and infants. Health care costs associated with formula feeding are estimated at $331-$475 per never-breast fed infant during the first year of life.[58] An estimated 72% of New Mexico mothers initiate breastfeeding with estimated 57.9% continuing at 1 month and 48.7% at 2 months. Those who are more likely to breastfeed are mothers >25 years old, have some post-high school education, are non-Hispanic White or American Indian; married, not on Medicaid and whose pregnancy was intended. Mothers who are less likely to initiate breastfeeding are teens (33%); Hispanic (30%), unmarried, on Medicaid (32%), working or going to school full or part time (27.2%). Among the 14 states

participating in PRAMS in 1997, New Mexico ranked 3rd highest for initiation at 72%; and 5th highest for prevalence of breastfeeding at one month of 58% of mothers.[59]

Figure 3: Breast Feeding Mothers in New Mexico



4. Healthy And Health Risk Behaviors Of Infants And Children

Child Abuse and Neglect, Children Age 0-17: The data presented is the best estimate given data limitations such as:

1) Cases are reported by age groups and a data base is not available for manipulation by MCH Epidemiology;
2) Population-based estimates for 1999 are based on 1998 census estimates;
3) Child abuse and neglect in American Indian children is managed by Tribal or BIA social service agencies thus Indian cases are under-represented in this report;
4) Second sets of rates are shown after removing 12% of children which is the estimate of American Indian in each age group and the population.
5) County level data is not available for this report and will be prepared in FY2001.

The Children's Protective Services (CPS) of the Protective Services Division of the Children Youth and Families Department (CYFD) oversees a statewide program. In FY1999, there were 23,201 "intakes", 11,470 "investigations", 20,363 "allegations", and 19,254 "victims". There were an estimated 1.6 victims per investigation. Of all investigations in 1999, 28% were substantiated; 51% were unsubstantiated; and 21% were pending at close of year.

Table 1: Children Protective Services Investigations FY 1999

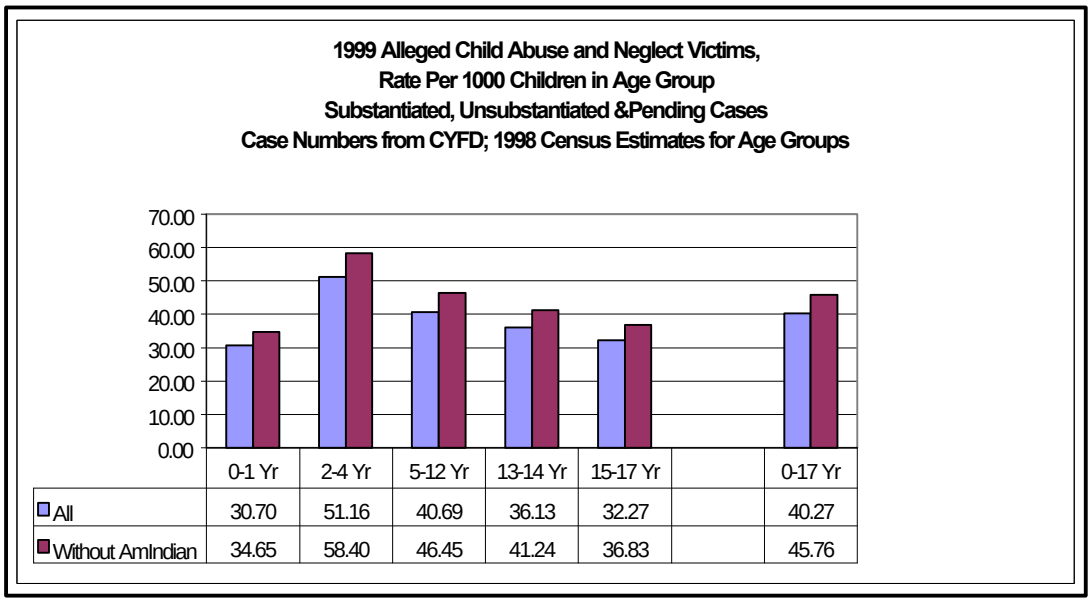
Investigation Summary:	No. of Investigations	Alleged Victims
Substantiated	3,228	4,641
Unsubstantiated	5,867	10,078
Pending at close of year	2,375	4,535
Total	11,470	19,254

Overall, an estimated 40.3/1,000 children age 0-17 were alleged victims of abuse or neglect in 1999. When Indian children are removed from the denominator, the rate increases to 45.8/1,000. According to CPS data, 4,641 cases or 24% were substantiated out of 19,254 alleged victims. 4,535 cases were still pending at year's end. Slightly over half of alleged victims cases, 52%, were not substantiated.

Among alleged abuse or neglect victims, the risk for females is 50.6/1,000 that is only slightly higher than for males at 49.4/1,000 population age 0-17 years. Data by age and gender was not available for this report. As seen in the table below, children ages 2-4 years have a 40% greater risk of being allegedly abused or neglected than infants and toddlers <2 years of age. Their risk of abuse is higher for the ages 2-4 than any other age grouping reported by CPS.

The figure below summarizes information by age for alleged victims. The CYFD does not have year end data for all substantiated cases. This figure provides an estimate of the burden on children and their communities, but does not show prevalence of substantiated abuse.

Figure 4: Abuse and Neglect Victims: Incidence by Age Group FY 1999



	0-1 Yr	2-4 Yr	5-12 Yr	13-14 Yr	15-17 Yr		0-17 Yr
All	30.70	51.16	40.69	36.13	32.27		40.27
Without AmIndian	34.65	58.40	46.45	41.24	36.83		45.76

5. Morbidity Measures In Infants, Toddlers And Children To Age 9 Years

a. Birth Defects: Birth defects are the leading cause of infant mortality in the state and continue to appear in the top five causes of death through age 19. An estimated 600 infants are so affected in about 27,000 births each year. Thus at least 1 in 45 live born infants had a major structural defect. One in 25 or 1,100 infants are born with at least one major or minor anomaly. Nearly 1,100 infants are born with at least one anomaly. The New Mexico Birth Defects Prevention and Surveillance System (BDPASS) Project produced the 1997-1998 Report in June 2000. The full text of this report is found in the Appendix.[60] Active surveillance is done for Neural Tube Defects (NTD's) and Oro-Facial Clefts (OFC's).

b. Neural Tube Defects: Nationally, NTD effects an estimated 1:1,000 live births and 4000 pregnancies every year.[61] One in 1,500 live births in New Mexico had an NTD in 1997-98 including anencephalus 5 cases or 1.3/10,000 live births; spina bifida 16 cases or 4.6/10,000 live births; and encephalocoele 3 cases or 0.4/10,000 live births. Inclusion of 5 prenatally diagnosed NTDs that were not live born increases the numbers by 25% in 1998. Numbers are small and so disparities are viewed with caution. Of the total 36 cases, higher numbers are seen in Hispanic mothers, less than a high school education, residence in southwestern counties (District III) and those with unknown data of entry to prenatal care.

c. Oro-Facial Cleft: In 1997-98, OFCs effected 1 in 620 New Mexican children. The estimated prevalence was 16.1 per 10,000. Of the total 87 cases, higher prevalence was seen in male infants born to an American Indian mother. Because of small numbers, this observation should be used with caution.

d. Newborn Genetic Disorders: In calendar year 1999, the Newborn Genetic Screening Program of Children's Medical Services reported the following cases; none of these numbers convert to rates higher than expected. A multi-year evaluation of data is needed to assess incidence because of small numbers.

> Congenital Hypothyroidism (CH): 15 children, 8 males and 7 females, with confirmed CH; 6 Hispanic and 4 non-Hispanic; diagnosis made 5-26 days of life. Treatment began at 12 days on average, range 1-29 days.
> Phenylketonuria (PKU): Two children with PKU, 1 male and 1 female. Diagnosis and treatment began at age 16 days.
> Galactosemia: One Hispanic male child with Galactosemia; Diagnosis at 20 days; dietary treatment at 23 days. There was 1 male with GALT Variant GN; 1 female with Duarte of LAG.
> Sickle Cell Disease: No children found with Sickle Cell Disease; 134 reported with trait hemoglobinopathies
> Congential Adrenal Hyperplasia (CAH): Two children were identified with Congenital Adrenal Hyperplasia; 1 classical and 1 non-clasical
> Biotinidase: No children were identified with Biotinidase.

e. Vaccine Preventable Diseases: New Mexico has the 3rd highest rate of pertussis in the United States with 100 cases reported in 1998. An outbreak of Rubeola occurred in 1991 (114 cases), 1995 (31 cases) and 1996 (17 cases).

f. Fetal Alcohol Syndrome (FAS), Fetal Alcohol Related Neurodevelopmental Deficits (ARND) and Alcohol Related Birth Defects (ARBD): The prevalence of FAS in New Mexico is estimated at 1/1,000 population of children <20; this compares favorably to the 1995 national prevalence estimate of 0.97/1,000 children. University of New Mexico researchers have reported a slight decline in FAS. There was variation in the range of the prevalence estimate for New Mexico, ranging from 0.31/1,000 to 3.09/1,000. Higher rates were reported in communities with a high percentage of Native American women. On average, a woman who has one FAS child has a risk of repeated events; a ratio of 0.28/1,000 non-Hispanic white women age 15-44 and 1.8-3.1/1,000 for Native American women age 15-44. An estimated 1/100 of children are likely to suffer some ARND with prenatal alcohol exposure a major cause of developmental delay.[62] New

Mexico PRAMS estimates that 44% of women drank alcohol in the 3 months before pregnancy thus creating a high level of in utero exposure.

g. Childhood Lead Poisoning: The New Mexico Childhood Lead Poisoning Prevention Program (NMCLPPP) reported screening 5,451 children age 0-5 in 1998, an estimated 3.4% of the population. The screening found 142 or 2.5% had an elevated level of $10 ug/dl; 42 had levels of 10-14 ug/dl or 1.4%; 42 had levels of 15-19 ug/dl or 0.8%; and 22 had levels $20 ug/dl or 0.4%. Since 1993, there has been 37,901 children <6 years screened. The prevalence of an elevated level is <2% based on less than 5% of children <6 years screened. Between 1993-1998, the leading sources of lead poisoning in 123 cases was Paint 22%; Parent occupation 15%; Soil 11%; Miniblinds 10%. Folk remedies, international exposure or lead-based pottery comprised 8%; pica was found in 7% of the cases. Remodeling 2%; other 2: and unknown 2% comprised the balance.[63] An estimate of prevalence based on 1996 screening predicted prevalence of 3,100-5,600 children. Lead poisoning risk is associated with paints used in pre-1950 housing. Only 15.5% of NM homes meet this criterion compared to 26.9% in the US. The estimate of prevalence of ~2.5% in NM is lower than the US rate of 4.4%.

In response to low screening coverage rates in New Mexico, the NMCLPPP (funded by a grant from the CDC) targets high-risk populations. Medicaid paid for the screening of nearly 60% of children screened in 1996. The Title V MCH CMS program pays for lead screening for the birth to 3 year old population of children at risk of developmental delay if there is no other payment source. Data suggest there are counties with higher risk than others so lead screening is targeted to these children: Cibola, Colfax, Grant, Lincoln, McKinley, Los Alamos, Sierra and Taos Counties. Children with levels of 10-14 ug/dl are confirmed by venipuncture; a home visit is done at 15-19 ug/dl; over 20 ug/dl appropriate medical interventions are used.

h. Children with Special Health Care Needs, Estimates of Prevalence: The National Health Interview Survey (NHIS) of the National Center for Health Statistics (NCHS) is the principal source of information for the non-institutionalized US population. Estimates of selected diagnostic categories for CSHCN were collected in 1997. These estimates are based on children <17 which is the census definition of children.[64]

The data from the 1998 Children's Chronic Conditions Registry (3CR) was compared to the 1997 NHIS prevalence estimates. Epilepsy and Down Syndrome were within the range of the NHIS prevalence. Two conditions were close to the range of the NHIS prevalence: diabetes was just 0.2% over the upper CI of the NHIS estimate and learning disability was just 0.2% under the lower CI of the NHIS estimate. Four conditions in the 3CR were from 1.3 to 1.9 times the NHIS prevalence estimates: cerebral palsy, muscular dystrophy, spina bifida and hydrocephalus. These high numbers may reflect institutionalized children and children over age 17 who may remain on 3CR files. Asthma in 3CR was

only 1/3 of the point estimate due largely to fact that 3CR lists children with moderate to severe asthma only based on treatment regimen in 3CR

Table 2: Comparison of Diagnosis in the NM Children's Chronic Conditions Registry and Prevalence Estimates of the 1997 National Health Interview Survey Prevalence Estimates for Children 0-17 Years

Condition	**No. in 3CR**	**NHIS Prevalence Estimate Age 0-17**	**NHIS 95% Confidence Interval**	**3CR number and NHIS estimate**
Diabetes	1,250	499,322 x 0.00140 = 699 children	174 ; 1,223	Only 0.2% over upper CI;
Epilepsy	2,250	499,322 x 0.00470 = 2,346 children	1,393 ; 3,400	3CR very close to point estimate
Asthma	12,942	499,322 x 0.06910 = 35,403 children	30,893 ; 38,113	Only 1/3 of point estimate; 3CR lists children with serious asthma only
Cerebral Palsy	1,737	499,322 x 0.00196 = 978 children	724 ; 1,228	1.4 times > than upper CI; difference of 509
Muscular Dystrophy	312	499,322 x 0.00031 = 154 children	65 ; 245	Nearly 1.3 times higher by 67 kids of upper CI
Spina Bifida	454	499,322 x 0.00028 = 140 children	45; 240	Nearly 1.9 times > by 214 kids of upper CI; includes institutionalized
Learning Disability	14,778	499,322 x 0.03262 = 16,287 children	15,059; 17,521	Low by 0.2% of lower CI or 281
Down's Syndrome	544	499,322 x 0.00085 = 424 children	259; 589	Within CI, on high end
Hydrocephalus	566	499,322 x 0.00051 = 255 children	75; 434	1.3 times > than upper CI; by 132; includes institutionalized

h. Asthma Hospitalizations, age 0-4 Years: In 1997 an estimated 2,000 infants and children age 0-4 were seen by a physician and diagnosed as having asthma as reported by the Children's Chronic Conditions Registry (3CR). In the same year, an estimated 329 children were hospitalized for asthma for a total of 424 hospitalizations. Thus an estimated 16% of children with asthma were hospitalized. Of those hospitalized, nearly 25% were hospitalized more than once. While the overall state performance is better than the national objective, there are important disparities in the data.

Some Indian Children were seen in community hospitals with the majority in IHS hospitals that are not in the numerator. Incomplete data for Indian Children from the Albuquerque I.H.S. units produced a rate of 42.24 in 1995 compared to 27.8 without Indian Children.[65] It is not known if NM Navajo data would push the state performance over the goal of <50/10,000. Between 1995-1998, the ratio for children age 1 (42.6/10,000) or 2 (31/10,000) years was greater than the ratio for children age 3 (26/10,000) or age 4 (21/10,000). Asthma diagnosis is infants less than one year old is considered premature by many clinicians.

Figure 5: Asthma Hospitalizations in Children

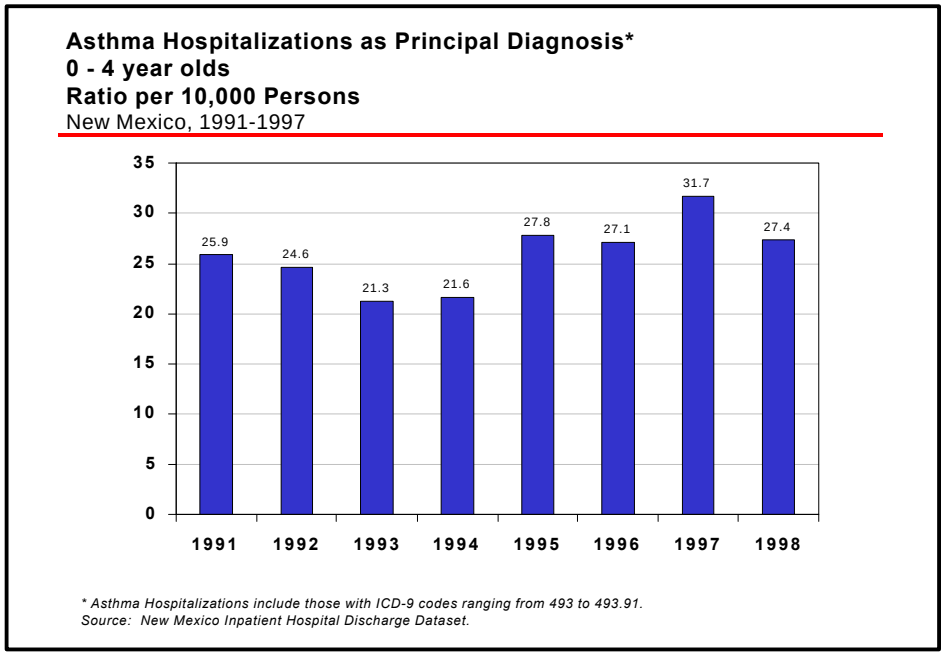
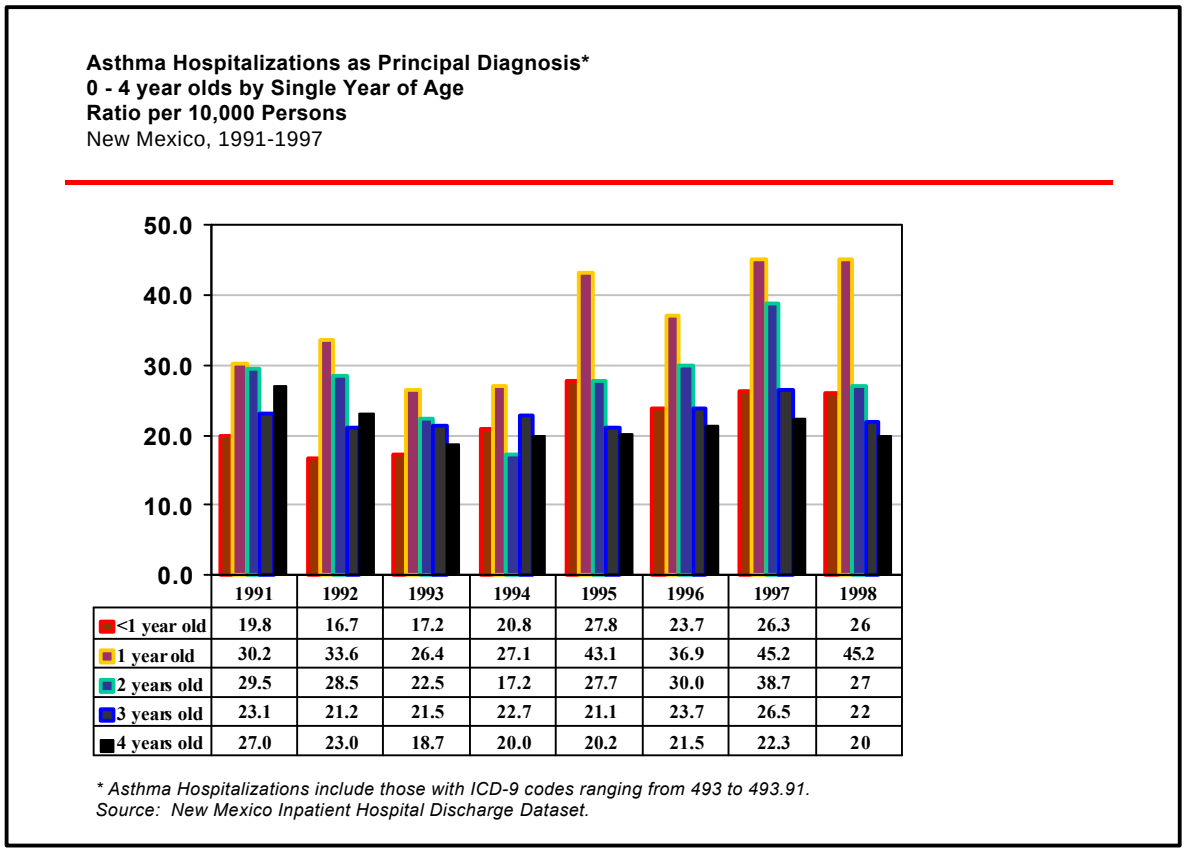
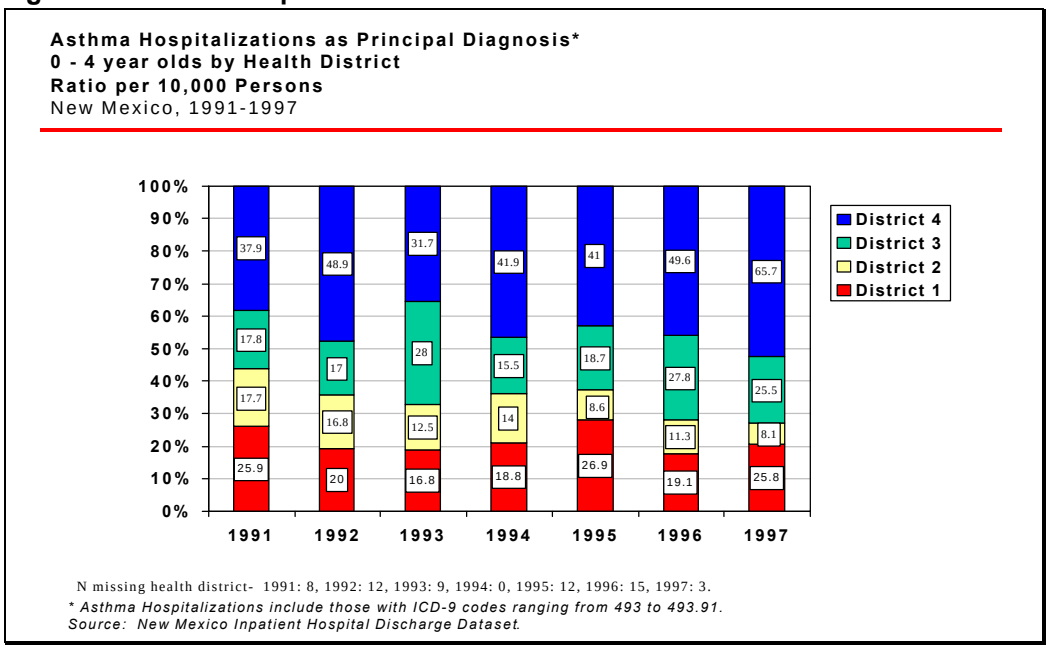


Figure 6: Asthma Hospitalizations in Children by Age:



	1991	1992	1993	1994	1995	1996	1997	1998
<1 year old	19.8	16.7	17.2	20.8	27.8	23.7	26.3	26
1 year old	30.2	33.6	26.4	27.1	43.1	36.9	45.2	45.2
2 years old	29.5	28.5	22.5	17.2	27.7	30.0	38.7	27
3 years old	23.1	21.2	21.5	22.7	21.1	23.7	26.5	22
4 years old	27.0	23.0	18.7	20.0	20.2	21.5	22.3	20

Figure 7: Asthma Hospitalizations in Children



Between 1991 and 1998, Primary Care access for children age 0-4 was in PHD District IV in the Eastern and south eastern counties of NM was significantly poorer than other Districts. In 1997 this area was worse than the national goal for the first time at 66/10,000.

Between 1995 and 1997 the majority of asthma hospitalizations were for children age 0-4 whose payor was Medicaid. Those without insurance were less likely to be hospitalized. Male Children are about two times more likely to be hospitalized for asthma: 39.6/10,000 males compared to 23.5/10,000 females in 1997

The statewide ratio for unduplicated children age 0-4 (24.6 in 1997) is lower than the ratio for all hospitalizations in children age 0-4 (31.7 in 1997). This indicates that some children have repeated hospitalizations, and less access to care.

Children more likely to be hospitalized more than once are age 1 or 2 years old; male children; children on Medicaid; children living in District IV.

Asthma Deaths, New Mexico, 1989-1997**:** During infancy, childhood, adolescence and youth years, there were 12 female deaths between ages 10-24 for a rate of 0.73/100,000 (pop 1636898) and 9 male deaths between ages of 1 and 19 years for a rate of 0.39/100,000.. These numbers are small and unreliable.[66]

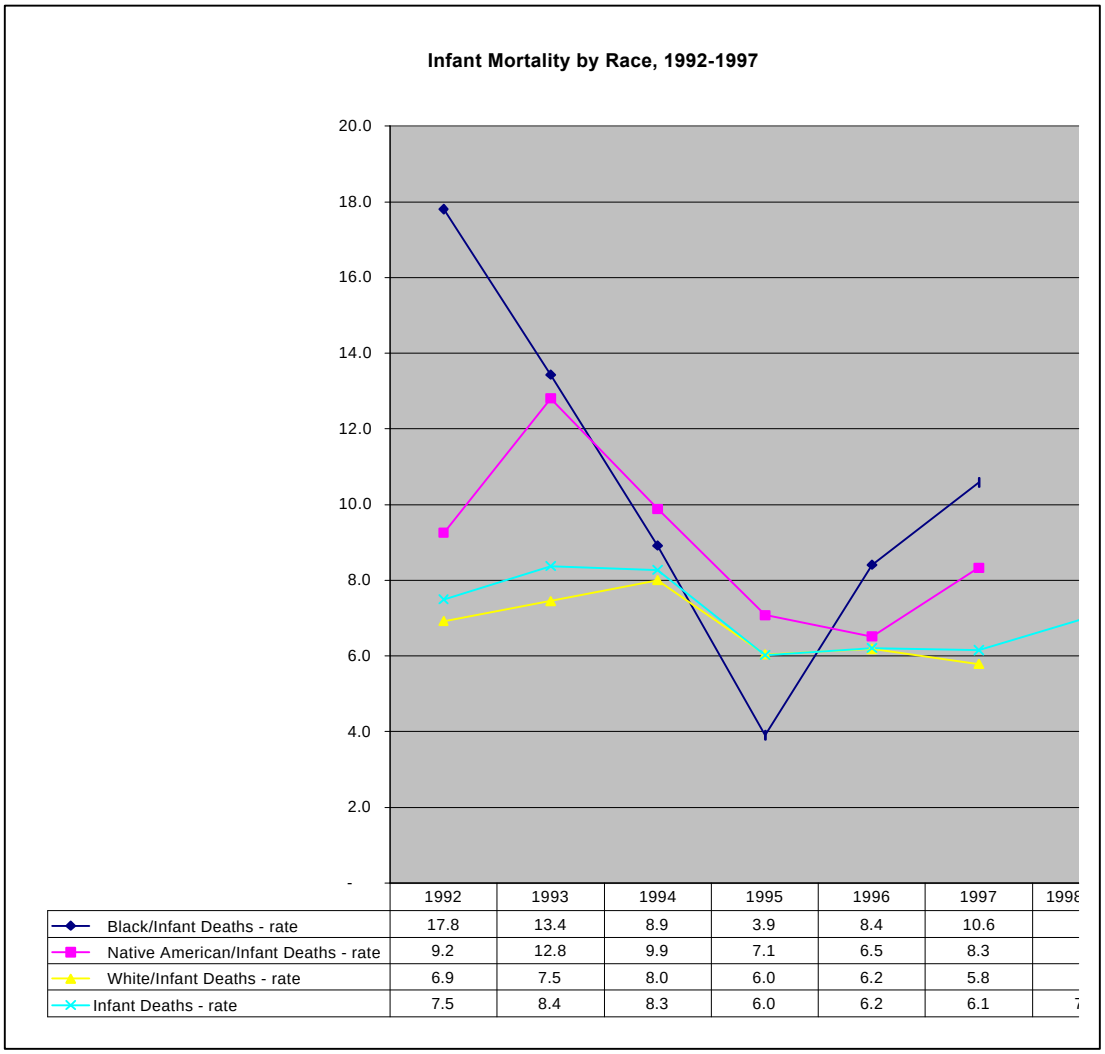
6. Mortality Measures In Infants, Toddlers And Children To Age 9 Years

a. Mortality in Children 0-10 Years of Age: Three age groups are covered in this section: infants, children 1-4 and children 5-9.

Infant Mortality: The overall infant mortality rate in New Mexico has shown some decline since 1990 from rates of 8.9 to a rate of 6.1 in 1997; and 7.0 in 1998. Most of the decline is due to changes in the postneonatal period. The slope of the trend line for neonatal deaths is -0.35 while that for postneonatal

deaths is -0.23. This means that a linear model predicts that the rate at which babies die in the first month has declined an average of 0.35 deaths per 1,000 live births each year. There were important gaps and disparities noted: Infants at greater risk of death were born of low birth weight, of American Indian or Black race, or to a mother who had no prenatal care at all. [67] While numbers for non-white infants are small (average birth cohorts of ~750 Black and 3,580 for American Indian) there are important differences in rates. The rate for white infants of 44.86/10,000 was higher than for American Indians at 34.4/10,000 and Blacks at 30.8/10,000. Elevated rates for whites were associated with congenital anomalies (13.5/10,000); preterm birth (11.5/10,000) and infections (6.3/10,000). Higher rates for American Indians were associated with congenital anomalies (13/10,000); infections (5.57/10,000) and conditions of the mother (4.6/10,000). Higher rates for Blacks were associated with preterm birth (13.2/10,000); conditions of the mother (8.8/10,000) and SIDS (4.4/10,000).

Figure 8: Infant Mortality Rate by Race



	1992	1993	1994	1995	1996	1997	1998
Black/Infant Deaths - rate	17.8	13.4	8.9	3.9	8.4	10.6	
Native American/Infant Deaths - rate	9.2	12.8	9.9	7.1	6.5	8.3	
White/Infant Deaths - rate	6.9	7.5	8.0	6.0	6.2	5.8	
Infant Deaths - rate	7.5	8.4	8.3	6.0	6.2	6.1	

Neonatal Mortality Rates by Cause: Of 243,757 live births, the five leading causes of death were congenital abnormalities at 15.34/10,000; short gestation or low birth weight at 9.39/10,000; infections at 7.43/10,000; conditions of the mother at 5.99/10,000; and other conditions of the perinatal period at 3.08.

Rates by Birth weight (1994-95): low birth weight is associated with a 10-35-fold increase in risk of death compared to infants born $2,500 grams (rate of 278.7/10,000 for LBW compared to 14.861 for normal birth weight). The use of surfactant and corticosteroids is thought to be associated with improved survivorship for respiratory conditions (rate of 53 in 1988-90 and rate of 9.9 in 1994-95) and preterm birth (rate of 101 in 1988-90 and rate of 82 in 1994-95).

Post-Neonatal Mortality Rates by Cause: Of 243,757 live births, the top five leading causes of death were SIDS at 12.51/10,000; congenital anomalies at 6.28/10,000; infections at 4.64/10,000; injuries at 2.79/10,000; and respiratory conditions at 1.23/10,000. Declines were seen in SIDS after 1995 associated with the "Back to Sleep" campaign. An increase of 23% was seen in congenital anomalies for 1994-96 over the previous periods.

Rates by Race (1994-96): Although numbers are small (average annual number of ~ 56 for White infants; 17 for American Indian infants and 9 for Black infants, the racial differences are significant. American Indian infants, rate 48.34/10,000, were nearly twice the rate of 25.25 for White infants. The rate for Black infants was 39.6 or nearly 50% greater than for whites. For American Indian children, deaths due to infections and congenital anomalies were 3 times higher than for white infants. For Black infants, deaths due to SIDS and injuries were 2-8 times higher than for white infants.

Rates by Birth weight (1994-95): The risk of death for low birth weight infants continues in this period compared to infants born $2,500 grams (overall rate of 64.31 for LBW and 20.41 for normal birth weight in 1994-95). The rates for leading causes are remarkably different: for SIDS, if LBW the rate was 19.79; if normal birthweight the rate was 9.31; for congenital anomalies, the rate was 21.44 for LBW and 2.58/10,000 live births if normal birthweight. From 1995-1997 the overall rate for the 509 deaths in 81,019 births was 6.28/1,000 live births. It was exceeded by 1) mothers whose prenatal care level was unknown or not stated, 73 deaths in 3,295 births = 22.15 deaths per 1,000 live births; 2) mothers who had no prenatal care, 24 deaths in 1,597 births = 15.03 deaths per 1,000 live births. Rates according to trimester of prenatal care use were 1st trimester 5.31; 2nd trimester 5.94; 3rd trimester 4.62.[68]

Mortality in Children 1- 4 Years and Children 5-9 Years: From age one, injuries surpass all other causes of death in children as seen in Table 3:

Table 3: Childhood Injuries in New Mexico

Leading Cause of Death, Children 1-4 Years		
3 year Average, 1997 - 1999		
Cause of Death	*3 Yr Total*	*3 Yr Avg*
Unintentional Injuries	66	18.1
Congenital Anomalies	23	7.0
Homicide	25	3.8
Malignant Neoplasms	13	2.9
Pneumonia/Influenza	5	1.8

Leading Cause of Death, Children 5-9 Years		
3 year Average, 1997 - 1999		
Cause of Death	*3 Yr total*	*3 Yr Avg*
Unintentional Injuries	36	8.2
Malignant Neoplasms	13	2.9
Congenital Anomalies	4	1.3
Homicide	4	1.3
Other Causes	2	1.0

Unintentional Fatal Injuries: The majority of these deaths from 1-9 years are associated with motor vehicle crashes as a passenger or as a pedestrian.

Unintentional Fatal Injuries, Age 0-14 years, ICD 800-869.9; 880-929.9: The death rate for unintentional injuries in children age 0-14 per 100,000 population has ranged from a high of 17.18 in 1990 to a low of 13.82 in 1997. This represents 66 and 57 fatal injuries respectively. Unintentional injury death account for 80% of all injury deaths in New Mexico for children aged 0-14 and 54% of all deaths. More people aged 1-14 years old died as a result of unintentional injuries than any other cause of death.

Comparison to United States: Since 1979, the New Mexico rate has been higher but roughly parallel to the US rate. In 1997, the state rate of 13.8/100,000 was 33% higher than the national rate of 10.41. Compared to other states, New Mexico has the highest unintentional injury death rate for all ages and has the 15th highest rate for youth aged 0-14.

Trend: The NM unintentional injury rate for youth aged 0-14 decreased dramatically between 1979 (30.88/100,000) and 1991 (14.59/100,000). Between 1991 to1997, the rate has remained relatively level.

Age: The 1995-1997 unintentional injury death rates are highest for infants aged 28-364 days (25.91 per 100,000 births, 21 deaths), followed by children aged 1-4 years old (20.22/100,000, 66 deaths). Children aged 1-4 and 10-14 were responsible for 70% of the 189 unintentional injury deaths among those aged 0-14 (35% of the deaths each).

By Gender: The 1997 unintentional injury rate for males (16.15/100,000) is 42% higher than the rate for females (11.36/100,000). Both male and female rates decreased between 1979-1990 and appear relatively level between 1991-1997.

By Race/Ethnicity: The 1995-1997 unintentional injury death rates for African American (24.64/100,000) and Native American (23.97, 100,000) youth were at least 75% higher than the rates for White, non-Hispanic (13.73/100,000) and White, Hispanic (13.66/100,000) youth.

By County: The 1993-1997 unintentional injury deaths rates ranged from 48.25/100,000 in Torrance county (8 deaths) to 0 deaths in 5 counties. Only 5 counties had 20 or more deaths. Seventeen of New Mexico's 33 counties had rates higher than the 1997 NM rate of 13.8/100,000, and 21 counties had rates higher than the 1997 US rate of 21/100,000.

7. Access To And Use Of Health Services

Immunization Coverage, Age 2 Years: Since 1994, immunization coverage reported for infants and toddlers age 19-35 months has gradually increased for the nation, from 74% to 81%. During the same period in New Mexico, rates increased from 1994-1996 from 75% to 80% and declined to 77% in 1997 and 73% in 1998. In 1998, coverage between 80-88% was attained for Hib, Hepatitis B, Polio and Measles vaccines; it was lower for DPT at 76%.[69] 1999, NM ranked 50th in the nation for coverage.

Racial and Ethnic Differences: For the period July 1998 to June 1999, the National Immunization Survey reported for children age 19-35 months for DPT, Polio and Measles that:

78.3% (95% CI 72.5, 84.1) of all children were up to date

73.3% (955% CI 64.7, 81.9) of Hispanic children were up to date;

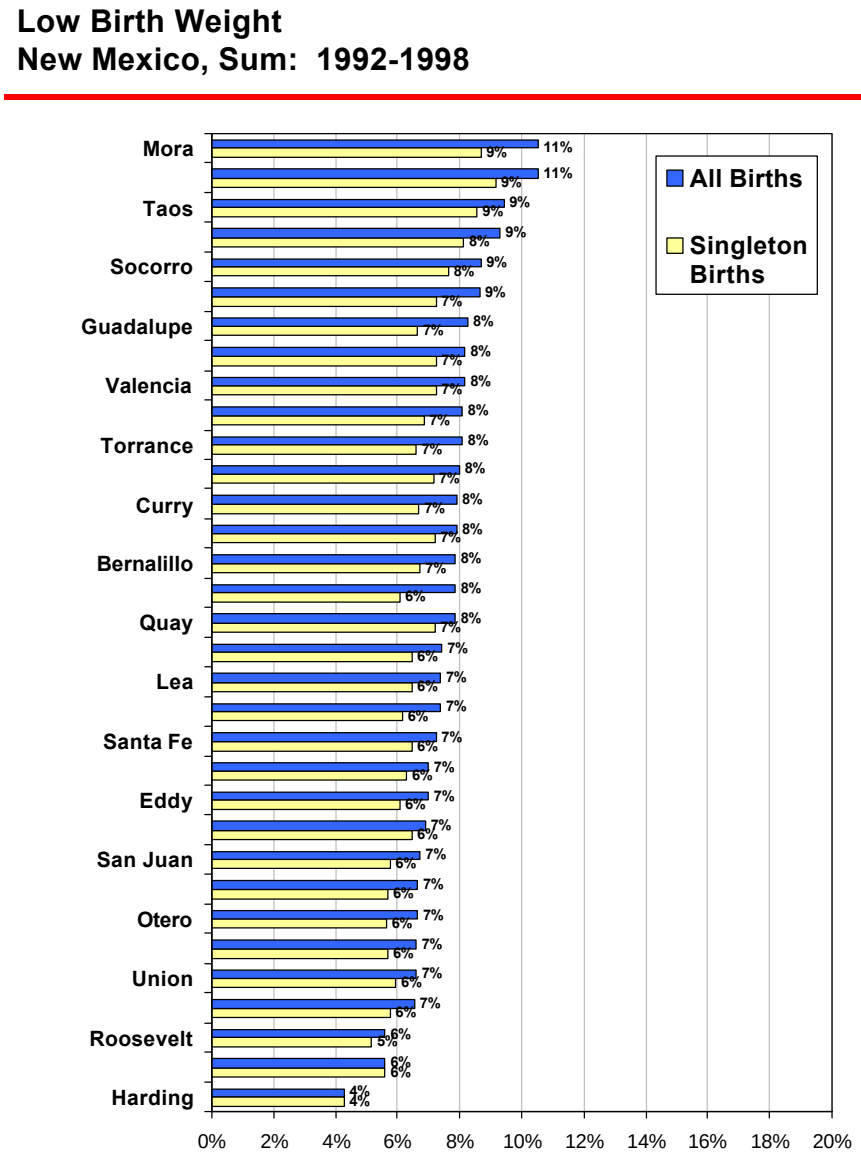
84.2% (95% CI 75.6, 92.8) of White non-Hispanic children were up to date.

Data for Black, Native American and Asian children were not reported due to small numbers in the survey[70]

Previous studies show that immunization coverage in New Mexico is highly correlative with prenatal care levels thus understanding prenatal care barriers and attitudes is critical. Factors associated with the decrease in immunization rates in New Mexico include:

1) Children living below poverty level have coverage rates 5-11% lower than children living above poverty level;
2) Infants who start DPT series before 3 months of age are twice as likely to be up to date at 24 months than those who don't start early;
3) Parents often think they are up to date when they are not;
4) Children with a "Medical Home" are more likely to be up to date than children whose parents use different sources for sick care than preventive care;
5) Missed opportunities in well or sick-child care could increase coverage by 8-16%;
6) Postal reminder cards can increase coverage and is cost effective compared to home visiting.

Figure 9: County Comparisons for Low Birth Weight



Note: Low Birth Weight is less than or equal to 2500 grams. Singleton Births exclude twins or triplets.
Source: Live Birth Files, New Mexico Vital Statistics

C: Health Of Pre-Teens, Teens And Youth, Age 10-24 Years

A statewide Needs Assessment provided local perspectives on health issues for teens and youth ages 10-24 Years. When assessing this population, participants from the four Public Health Districts of the Public Health Division demonstrated a high level of experience and understanding of the developmental underpinnings for health in this group, and the critical factors involved in primary or preventive services:

- Need to feel respected and that privacy and confidentiality will be assured in health and health related services. While many qualify for Medicaid only an estimated 20% have a card and use the services; this is likely related to parental permission required by Medicaid.
- Many youth who get into serious health risk behaviors that have a potential for life long consequences have a history of problems dating back to their earliest years meaning that moderate warning signs may not be acted upon by the child or the child's family.
- Thirty percent of this population lives at or below the FPL; morbidity, mortality, injury and serious health risk behaviors are associated with poverty in this age group.
- Strategic planning for this age group requires that youth are engaged in the process and that everyone involved is aware of critical dimensions such as cultural affiliations, discrimination and racism issues, gender issues, power and class relations, self-esteem issues, family and school connectedness and that basic needs are addressed.

Participants articulated priority public health concerns for this age group along with related health service gaps. The majority of the issues have a root cause in social determinants of health, serious health risk behaviors and the environment in which teens come of age in New Mexico:

1. <u>Needs Assessment Summary</u>

Priority Health Concerns:

- 30-34% of 7th grade students reported use of alcohol and tobacco before age 13.
- Injuries related to alcohol and drugs including MV crashes and firearm caused injuries
- Motor vehicle or transportation related fatal or non-fatal injuries
- Preteen and young teen sexual activity, STDs and pregnancy
- Mental health issues including depression, suicide; homelessness in teens
- Coping with family breakdown; turning to gangs for "family support"
- Violence within families and among peers, need for more community policing.
- Physical inactivity and poor diet, obesity; diabetes; asthma
- Life Circumstances: sudden unemployment of a large portion of Hidalgo County.
- Type I diabetes in school age children (i.e., Belen Schools currently have over 13 students who are Type 1 that is an increase from 4/4500 in 1994).
- Culturally appropriate information and tools for parents on adolescent reproductive health.

Lack of Health Services (clinics, providers, specific services):
Emergency Medical Services along the border counties. Immigration and Naturalization (INS),or other immigration entity is needed to support this effort
Prenatal Care (Guadalupe, DeBaca Counties)
Lack of mental health and psychosocial screening and services or life learning experiences
Denial about illness and don't follow up until complications
Lack of dental care, mental health care providers, especially for Medicaid clients.

Issues of School Health:
Need sex education in lower schools and access to birth control in middle schools.
Teen pregnancy is high and for Native American youth it is accepted in the community. Create a system that will allow school districts to follow the same criteria. The current curriculum does not seem to work.
Appropriate services for Native American youth population in Public Schools. There is concern that Native American youth who attend the Public Schools and not the Indian or Day Schools (where they are regularly seen by IHS providers) are "lost" in a system that does not really meet their needs.

Need Community Based System of Care:
There is a tremendous need to facilitate adolescents "getting through the system" and to strengthen coordination between schools, Departments of Health and Education and the broader community.
Coordination issues include limited interaction between schools, parents and medical providers, and a lack of organized community support for initiatives or services that support youth.
Integration of youth services needs to be assessed and improved among programs within agencies and communities. Data needs to be shared.

Problems of Health Care Costs and Health Insurance:
Undocumented populations especially in border counties lack coverage.
Need Healthier Kids Fund brought back for additional coverage
Economic constraints; limited employment opportunities
HMO carrying primary provider or specialist; difficult for adolescents to access confidential health services, Medicaid system non-responsive to this group's needs, language and cultural barriers, medical interpretation needs and a large undocumented population with no access to care.
Need for "youth friendly" services: appropriate hours, walk-in vs. appointments, knowledge about confidentiality (parental consent), information on contraceptive options and family planning services, lack of activities for adolescents with learning disabilities.

The following domain wheel visually depicts key areas of importance for this age group.

ADOLESCENT MCHB NEEDS ASSESSMENT
DOMAINS SIGNIFICANT TO AN ADOLESCENT WITH IMPLICATIONS FOR PUBLIC HEALTH

Lifestyle
Nutrition, Exercise
Environment
(**VAST)**
Alcohol, Substance Abuse Tobacco Safety, Violence,

Employment
Training, Opportunities
Transition to Self Sufficiency
Health Insurance

Family Support
Parents, Siblings
Extended Family
None

School
Transition from Middle School to
High to Post Secondary Ed.
Transition to Work
Drop Out

Institutionalization
Incarceration
Treatment Centers
Rehabilitation

Psychosocial Support
Peer ,Recreational
After school, Mediation

Available Resources
" Best Practice" Research
Services and Information

ADOLESCENCE
10 - 24 years of age

CSHCN
Transition through school
Transition to Adult Health Care

Socio – Economic
Descriptors

Youth as Parents
Academic Education
Parenting Education
Financial Resources
Transition to Work

Injury
Intentional and Unintentional
Disease, Abuse

Sexual Behavior
Teen Pregnancy
Age Inappropriate
Abstinence

Homeless
Runaways, Emancipated
Independent Living
Shelters

Access to and Utilization of
Health and Health related
Physical, Mental, Dental
and Insurance Coverage

Assets/Protective Factors

10-14 15-17 18-21 21-24

2. Socio-Demographic Overview

In 1998, there was an estimated 256,274 preteens and teens age 10-19 and 106,225 young people age 20-24. A rule of thumb about this age group is that there are generally 25,000 youth for each year of age between 10 and 24. Over half of this population is of Hispanic, Native American or African American families. More than 2/3 live in metropolitan or urban areas although most of the communities are small and distances between urban areas is large. There are no estimates of the undocumented population for this or any other age group although many youth are legal citizens living with parents who may be undocumented.

Poverty: An estimated 30% of youth <18 years of age live below the Federal Poverty Line (FPL) and 14% live below 50% of the FPL
Health Insurance, Health Coverage: An estimated 20.7% have no health insurance compared to 14.8% nationally, those at or below of the FPL have higher rates of not being insured.
Youth in School: In the 1997-98 school year, an average 7.8% of youth in grades 9-12 dropped out of school in New Mexico. The range was 1.8% in Los Alamos County (the state's most affluent) to 15.3% in Rio Arriba County.
Homeless Youth: There are no estimates of the number or geographic distribution of homeless youth in the state. Public health district staff report this as an issue of growing concern.

3. Social Determinants Of Health In Preteens, Teens And Youth

As with all population groups in this assessment, the domains of assessment indicate the importance of the social determinants of health. Assessment for this age group is based on appropriate developmental tasks such as the need to become independent, to understand sexual selves; to change relationships with parents, to deepen friendships and to focus on goals and ambitions. Getting along with peers and rule-abiding behaviors are of critical importance to success in school and to health.[71] Social supports influence the health behaviors of preteens, teens and youth as the social environment provides clues on how to accomplish developmental tasks. Peers, family members, significant adults, neighborhoods, mentors, school staff, community members and the media become examples to follow or to reject. Philosophically, the Adolescent Health and Youth Development (AHYD) program operates from the view that young people are assets to be developed rather than problems to be managed.

4. Healthy And Health Risk Behaviors

The incidence of youth injury and sexual behaviors has decreased during the past decade according to the Centers for Disease Control and Prevention's 1999 Youth Risk Behavior Surveillance System (YRBSS) report. [72] The biannual YRBSS focuses on six priority areas: 1) behaviors that lead to intentional and unintentional injuries, 2) tobacco use, 3) alcohol and other drug use, 4) sexual behaviors, 5) dietary behaviors, and 6) physical activity. For the 1999 report, students in grades 9 through 12 completed 15,349 questionnaires. Between 1991 and 1999 there were decreases in the percentages of students who never or rarely wore seatbelts (37% decrease), carried a weapon (34% decrease), and had

ever had sexual intercourse (8% decrease). The percentage of sexually active students who used a condom at last intercourse increased by 26%.

Results from the 1999 YRBSS indicate the following:	From the NM 1999 YRBS:
♦ 50% of students currently used alcohol;	54.3%
♦ 35% of students currently used cigarettes;	38.0%
♦ 27% of students currently used marijuana;	32.0%
♦ 50% of students had engaged in sexual intercourse;	52.3%
♦ 36% of students had been in a physical fight; and	36.5%
♦ 17% of students had carried a weapon.	25.0%

The U.S. YRBSS also found that almost 1 in 10 high-school students were overweight and 16% were at risk for being overweight. Less than one quarter of high-school students ate the recommended daily allowance of fruits and vegetables.

The 1999 New Mexico YRBS Summary reported that:

- 75% said they felt depressed, worried, tense, or anxious at least one day out of the past 30 days.
- 76% wore seatbelts all or most of the time
- 35% said they had never smoked a whole cigarette
- 20% were 14 or younger when they first smoked; 83% when they first drank alcohol; 42% with first try of marijuana
- 18% females and 10% of males reported going without eating for 24 hours or more
- 12% of females and 8% males reported taking diet pills, powders or liquids to lose weight without a doctor's advice
- 48% said they do not take a physical education class
- 20% watched 4 or more hours of TV on an average school day.

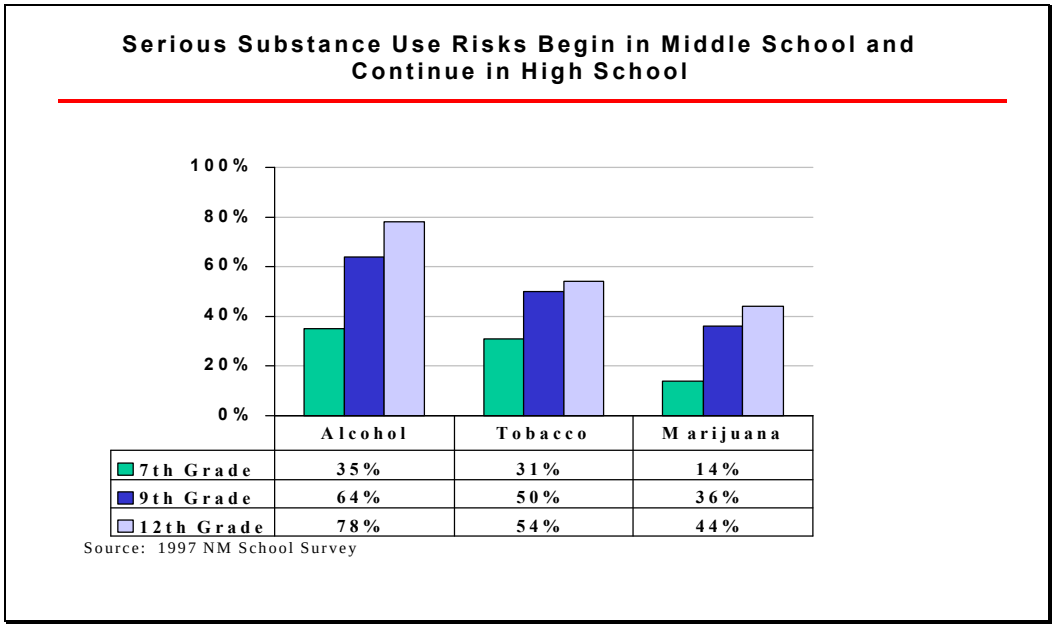
The CDC report on youth in the United States reported that almost three-fourths of all deaths for ages 10 to 24 result from 4 causes: motor vehicle crashes, unintentional injuries, homicide, and suicide. The 1999 YRBSS indicates that many high-school students engage in risky behaviors (e.g., drinking and driving, carrying a weapon) that may increase their likelihood of dying from these causes.

Serious Health Risk Behaviors: The assessment of youth risk behavior is widespread in New Mexico and includes the New Mexico School Survey sponsored by Drug Free Schools; the Search Institute Assessment of Youth Development; and the Youth Risk Behavior Survey (YRBS). Only the NMSS and Search include youth in middle or junior high schools. Survey results indicate that significant proportions of preteens and young teens are engaging risk behaviors that have life long consequences. The 1997 New Mexico School Survey (NMSS) data supports that effort to reduce serious health and social risk behaviors need to start in elementary grades. By middle school, evidence of serious health and social risk behaviors was present. Alcohol, cigarettes and marijuana are the substances used most commonly by adolescents. The greatest increase for past-year substance use occurred between 7th and 9th grades as seen in the figures that follow this discussion.

Table 1: Substance Use in Youth, New Mexico 1997

Substance	Mean Age of First Use	NM: Overall Use	USA: Overall Use
Tobacco	11.3 to 12.7	52%	50%
Alcohol	11.6 to 13.3	71%	69%
Marijuana	11.9 to 13.4	41%	33%

Figure 1: Substance Abuse Risks



Based on results from the NMSS, substance use during the past year was 10 times higher among youth that reported having friends who used for any of the substances. School and non-school friends are a common source for obtaining licit or illicit substances. Students who were more likely than others to use alcohol, tobacco or other drugs were depressed or reported low self-esteem; were in a single parent home, with step parents, no parents; did not have material needs met; performed poorly in school; and had parents who seldom established clear rules. Lower rates of substance use were associated with students who reported having close adults available to talk to about problems, who spent after school hours in supervised activities or with a parent or guardian.

Other risk behaviors reported are driving while drinking or using drugs (24%); shoplifting (33%); damaging property or physically hurting someone on purpose (25%); carrying a weapon to school in previous month (15% high school, 10% junior high) and seeing others with weapons at school (30%).[73] The 1999 Profile of Student Life Report had similar findings such as alcohol, tobacco and drugs experimentation in 6th grade doubling or tripling in prevalence from 7th to 9th grades, continuing to increase to 12th grade.

5. Protective Factors And Health Risk Behaviors

Recognizing that the "social capital" of developmental assets is protective against youth engaging serious behavioral health risks, the Adolescent Health and Youth Development program works actively to involve communities in the Search Institute's Youth Development Assessment and Planning process. Assessments demonstrate the protective effects of feeling connected to family and to school, having a caring, responsible adult to talk with, involvement in extra-curricular activities or interests, the personal attributes of healthy self-esteem, doing well in school and social endeavors.[74] Using the Search Institute's assessment tool that features 40 developmental assets, 20 internal and 20 external, New Mexico youth between grades 6-12, have 18-20 assets on average.

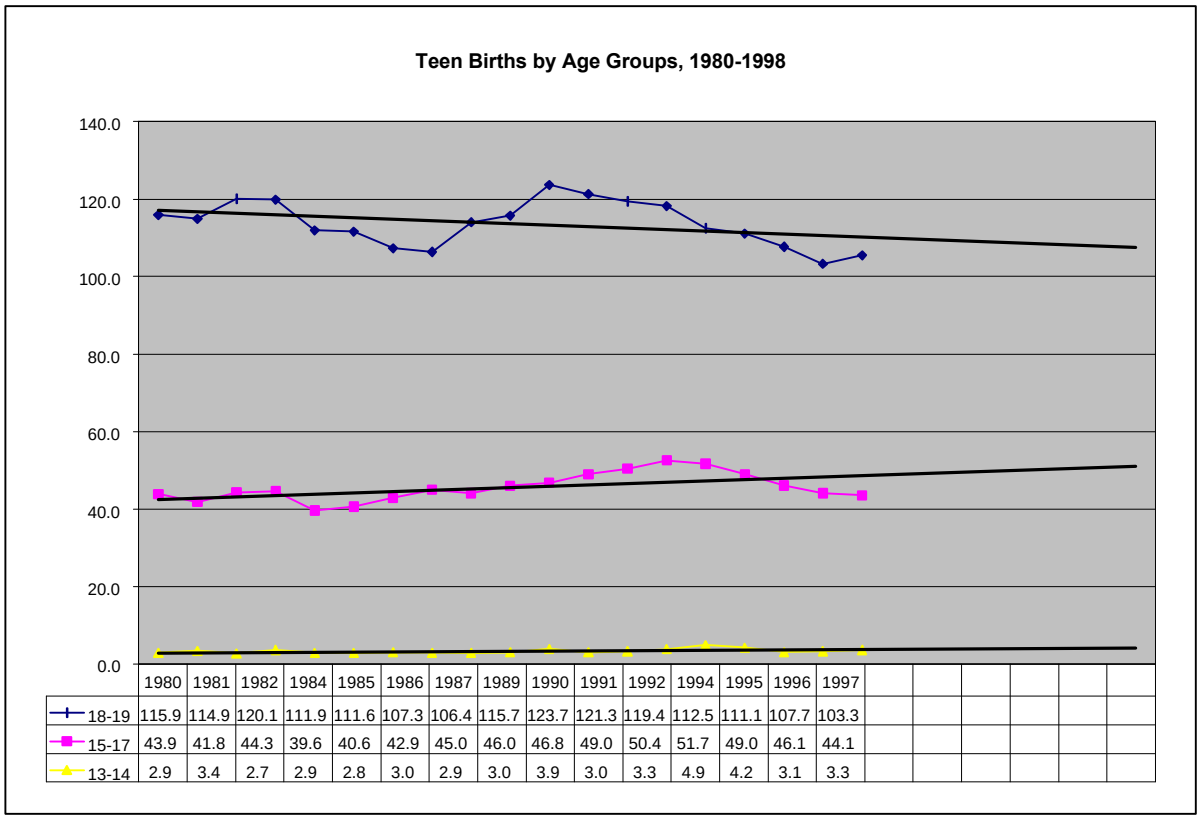
6. Teen Pregnancy And Teen Births

In 1997, New Mexico ranked 48th worst in the nation for the percent of births to teens <age 20 with 17.9% of total births (National average 12.7%, range 7.4% in Massachusetts to 20.7% in Mississippi). In the same year, New Mexico ranked 20th in the nation for the percent of teen births to mothers who were already mothers at 19.6% (National average 21.6%, range 13.5% in Vermont to 31% in the District of Columbia).[75] Specific issues for each age group are:

> Age 13-14: The birth and pregnancy rates for teens age 13-14 show a disturbing increase between 1980 and 1998. In 1980, there were 66 live births and 35 abortions; in 1998 there were 103 births and 43 abortions. Birth rates were 2.9 in 1980 and 3.6 in 1998; Pregnancy rates were 4.4 in 1980 and 5.1 in 1998, a 13% increase. The abortion ratio has shown variation between 1.2 and 2.0.
>
> Age 15-17: In spite of recent downward trends in the US and in New Mexico, the rates for teen pregnancy or teen births in those age 15-17 have not appreciably declined since 1980. Between 1980-1998, there has been a slow but gradual increase of 0.6 in the rate per year in the birth rate; similarly between 1990-98 a gradual increase of 0.56 per year; between 1993 and 1998 a decline of -1.17 in the rate but not statistically significant. Thus there were variations with birth rates as high as 52.6/1000 in 1993; but the rate in 1980 of 43.9/1,000 is only slightly higher than the rate of 43.5/1,000 in 1998. Pregnancy rates are somewhat lower with a decline in the abortion ratio for this age group from 14 in 1980 to 11 in 1998. The pregnancy rate in 1980 of 58.2/1,000 is higher than the rate of 54.8/1,000 in 1998. Rates varied significantly by county, from a low of 17.5 in Los Alamos (the most affluent county in the state) to a high of 76.4 in Socorro County.
>
> Age 18-19: The birth and pregnancy rates for teens 18-19 declined for the period 1980 to 1998. As with younger teens, there has been variation in rates with a high of 123.7 in 1990; yet the rate of 115.9 in 1980 was approximately 10% higher than the rate of 105.5/1,000 in 1998.

The following figure depicts age specific trends in teen birth rates since 1980. Data also suggests a decline in rates from 115/1,000 to 110/1,000 for 18-19 years old; an increase in rates from 43.9/1,000 to >50/1,000 by 2005 for 15-17 year olds; and for 13-14 year olds the predicted rates show a very slight increase from 2.9/1,000 to 4/1,000. The data also suggests for 18-19 year olds a decline in rates from 112.5/1,000 to 901,000; for 15-17 year olds a decrease in rates from 51.7 to 30/1000; and for 13-14.

Figure 2: Teen Birth Rates by Groups



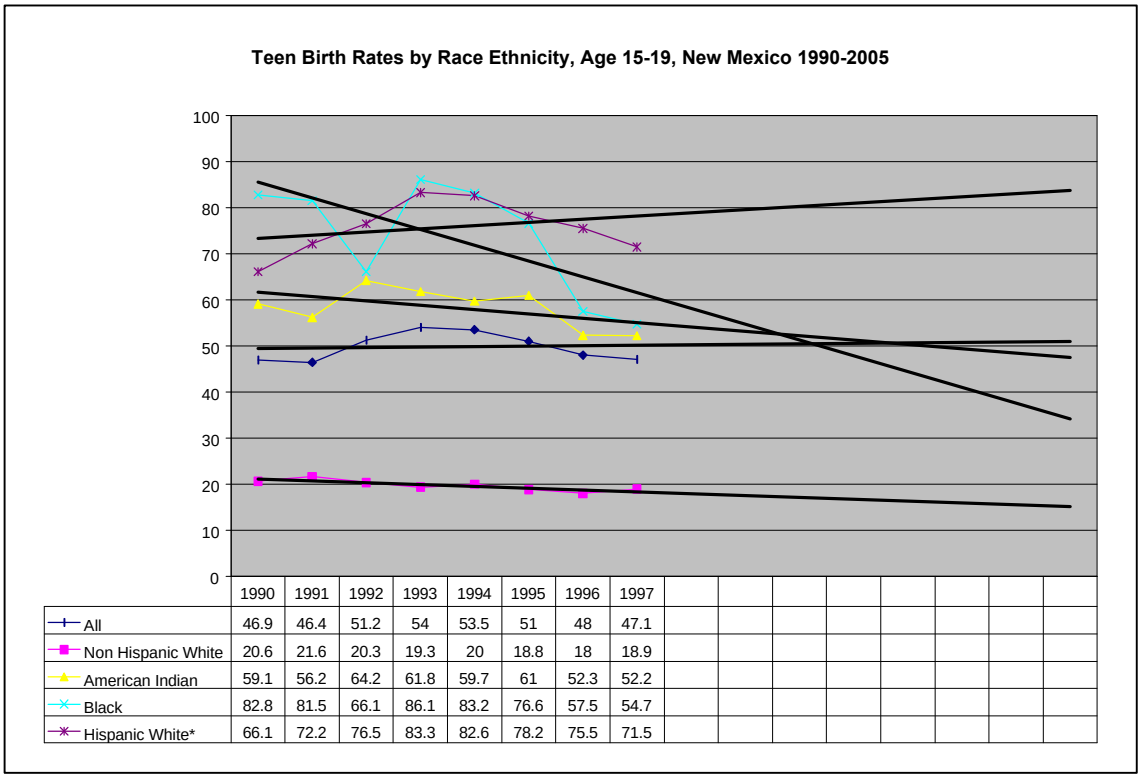
	1980	1981	1982	1984	1985	1986	1987	1989	1990	1991	1992	1994	1995	1996	1997
18-19	115.9	114.9	120.1	111.9	111.6	107.3	106.4	115.7	123.7	121.3	119.4	112.5	111.1	107.7	103.3
15-17	43.9	41.8	44.3	39.6	40.6	42.9	45.0	46.0	46.8	49.0	50.4	51.7	49.0	46.1	44.1
13-14	2.9	3.4	2.7	2.9	2.8	3.0	2.9	3.0	3.9	3.0	3.3	4.9	4.2	3.1	3.3

Disparities by Race and Ethnicity: There are significant disparities for teen birth rates, ages 15-19, by race and ethnicity. However, the degree to which race and ethnicity may be a proxy for poverty or the different experiences of various cultural groups with teen pregnancy is not well understood. A constant across all groups is that teen child bearing is associated with failure to complete high school, single parenthood in the young and very low income. Overall rates varied from a low of 46.9 in 1990 to a high of 54 in 1993; declining to 47.1 by 1997. Census estimates for 1998 and 1999 were not available for this analysis. The graph on the next page shows racial disparities for births to teens age 15-19. This graph has a trend line that runs from 1990 to 2005. In summary, between 1990 and 1997:

- Hispanic White teens show the lowest rates with a decline from 20.6 to 18.9; projecting further decline to 15/1000 in 2005
- Non-Hispanic White teens show the highest overall rates with an increase from 66 to 71.5/1000; projecting a further increase to 85/1,000 in the year 2005
- Black teens show the steepest decline from 85 to 54, projecting a further decrease to 35/1,000 in the year 2005. Black teen births are few in number (50 age 15-17 and 69 age 18-19) comprising less than 2% of teen births
- American Indian teens have had a steady decline in teen births from 59/1,000 in 1990 to 52/1,000 in 1997. The graph shows a further decrease to 49/1,000 by the year 2005.

The trend line featured below is based on 8 years of data, including a period of increase and decrease in teen births. Thus the trend line must be used with some restraint. It assumes those cultural norms, community resources, individual resources and teen pregnancy prevention resources would remain fairly constant from 1998 to 2005.

Figure 3: Teen Birth Rates by Ethnicity



	1990	1991	1992	1993	1994	1995	1996	1997
All	46.9	46.4	51.2	54	53.5	51	48	47.1
Non Hispanic White	20.6	21.6	20.3	19.3	20	18.8	18	18.9
American Indian	59.1	56.2	64.2	61.8	59.7	61	52.3	52.2
Black	82.8	81.5	66.1	86.1	83.2	76.6	57.5	54.7
Hispanic White*	66.1	72.2	76.5	83.3	82.6	78.2	75.5	71.5

7. Violence And Non-Fatal Injuries

Violence and Vandalism in Schools: There are 89 independent school districts all of which report violence or vandalism to the State Department of Education. Total reported incidents of violence or vandalism for the 1997-98 school year was 14,835. Using a rough estimate of 346,000 children in New Mexico schools, this yields a rate of 42.8 student incidents/1,000 student population. This is a 15.4% increase over the previous school year. Incidents have been on the increase since 1992 when there were only 5,305 incidents. In 1997-98, there were 6,871 violent crimes (assault/battery) in which students were perpetrators 96.27% of the time; 3,614 acts of vandalism costing a total $5.3 million in repairs or replacements; 2,264 incidents involved drugs; and 708 incidents involving alcohol. The Guns Free Schools Act has shown some effect, as there is a 47% reduction in incidents of possession since the previous year.[76]

Abuse and Neglect: In 1999, an estimated 41/1,000 youth age 13-14 and 37/1,000 age 15-17 were alleged victims of abuse or neglect. The rates for substantiated cases are about one-third to one-half of this rate. This estimate excludes American Indian youth from the denominator as Tribal or BIA social service agencies serve these youth. Nearly a third of male and female youth in grades 6-12 had been physically abused by a member of the family or someone living with them (got scarred, black and blue marks, welts, bleeding or broken bone) and a third reported being a victim of physical violence where someone caused them physical pain or injury. [77]

Motor Vehicle Accident: The New Mexico Traffic Safety Bureau reports that 15-19 year olds have the highest crash involvement rate of any age group at 170.4 driver involvements per 1,000 drivers (all ages ranged 40.44 to 170.4). Youth age 15-19 accounted for 18% of serious injuries, but only 7% of total licensed drivers. Alcohol was associated with over 50% of non-fatal crashes with youth at the wheel.[78]

8. Morbidity For Preteen And Youth

Nutrition and Physical Fitness: 55% of males and 52% of females paid attention to healthy nutrition and exercise. Oddly, these proportions were higher in 6th grade than in 12th grade. Bulimic or anorexic behaviors were self-reported by 18% of males and 21% of females with no trend by grade in school noted.

Mental Health Estimates: "Thriving indicators" are higher in number and diversity in youth who have higher numbers of developmental assets. Over 75% of male and female students reported not giving up when things get difficult and helping friends or neighbors 1 or more hours per week; over 50% reported placing high importance on getting to know people of other racial or ethnic groups, having been a leader of a group or organization in the past year and paying attention to healthy nutrition and exercise.
An average of 11.5% of males and 20% of females felt sad or depressed most or all of the time in the last month; 14.5% of males and 24.5% of females said they attempted suicide one or more times. In 1995, 23% of 9-10th graders reported seriously considering suicide in past 12 months and 11% made an attempt.[79] The New Mexico Tribal Suicide Prevention plan reported a reduction in rates of 59.8/1,000 to 10.9/1,000 in 1996-97 for youths ages 15-19.[80]

Substance Abuse: Nearly 90% of overdose hospitalizations are E-coded and the data for hospitalizations indicate that this is a serious problem in New Mexico. Although numbers and rates cannot yet be released, it is a priority for the Department of Health.

School Based Health Centers (SBHCs): In 1998-99, there were 8,089 students served in 38 SBHCs across the state. The majority of SBHC serve youth in middle and high schools. Of 21,639 visits, 61%

were for basic primary care, 20% for family planning services or STD treatment, 16% for mental health, and 3% for injuries or dental needs.

9. Mortality Preteens, Teens And Youth

The Child Fatality Review (CFR) team considers all unintentional deaths of children. Among preschool age children, reviews showed that minimum inattention by parents and caregivers contributed to deaths. High risk behavior includes: leaving a small child unattended in the bath tub, swimming pool or bucket of water, being run over in the driveway as children are often invisible to the driver, and being trapped in the trunk of a car. The CFR recommended exploring technology that would alert the driver of motion in the trunk or behind the vehicle. The 10-14 year old age is a relatively safe time for children. "Horsing around" and adventurous play can lead to tragic consequences. Unfortunately, pre-teens tend not to think in terms of consequences of their behavior. Three 10 year olds have died in separate accidental hangings near a tree house or upstairs porch. Young people are tempted to experiment with alcohol and guns. Boys seem especially likely to engage in risk taking activities. Adolescents are very concerned about what their friends think and when they died of unintentional injuries, they are seldom alone. At this age, young people are tempted to experiment with alcohol and play with guns. Boys seem especially likely to "be in the wrong place at the wrong time" and to engage in risk taking activities.

Table 2: Leading Causes of Death

Leading Cause of Death, Ages 10-14 Years

3 year Average, 1999 - 1997

Cause:	*3 Yr total*	*3 Yr Avg*
Unintentional Injuries	66	22.0
Suicide	13	3.0
Malignant Neoplasms	12	2.8
Homicide	9	2.1
Heart Disease	4	0.9
Congenital Anomalies	4	0.9

Leading Cause of Death, Ages 15-19 Years

3 year Average, 1999 - 1997

Cause:	*3 Yr total*	*3 Yr Avg*
Unintentional Injuries	213	49.2
Homicide	68	15.7
Suicide	65	15.0
Malignant Neoplasms	23	5.3
Heart Disease	9	2.1
Congential Anomalies	7	1.6

Cause of Death, Youth 20-24 Years

3 year Average, 1999 - 1997

Cause	*3 Yr total*	*3 Yr Avg*
Unintentional Injuries	236	66.6
Suicide	92	30.4
Homicide	81	27.0
Cancer	22	7.3
Heart Disease	11	3.7
Cong. Anomalies	4	1.3

Overall, the following trends are noted:

- Males have consistently higher rates than females for injury deaths.
- Rates for Hispanic, Black, American Indian are higher than for non-Hispanic White in all injury categories. 75% of unintentional injuries in these groups are motor vehicle crashes.
- High rates of homicide and suicide are seen in preteens, teens and youth; the majority is male with rates for males being at least 6 times those of females.
- Cancer deaths rank 3-4th in these ages; largely cancers of blood forming organs
- Heart disease and Congenital Anomalies tie for 5th place in these three age groups. With congenital anomalies the leading cause of infant mortality, premature death is seen in all age groups from 0-24 from various birth defects.

Because unintentional injuries, homicide and suicide are the leading causes of death for preteens and teens age 10-19 and youth age 20-24, gaps and disparities are described here. Over half of unintentional injuries are motor vehicle crashes of which a third involve alcohol.[81] Youth age 15-19 accounted for 11% of all traffic deaths; alcohol was involved in 44% of these crash deaths.[8]

Unintentional Fatal Injuries, Ages 0-14 years, ICD 800-869.9; 880-929.9: The death rate for unintentional injuries in children age 0-14 per 100,000 population has ranged from a high of 17.18 in 1990 to a low of 13.82 in 1997. This represents 66 and 57 fatal injuries respectively. Unintentional injury deaths account for 80% of all injury deaths in New Mexico for children aged 0-14 and 54% of all deaths. More people aged 1-14 years old died as a result of unintentional injuries than any other cause of death. The 1995-1997 unintentional injury death rates are highest for infants aged 28-364 days (25.91 per 100,000 births, 21 deaths), followed by children aged 1-4 years old (20.22/100,000, 66 deaths). Children aged 1-4 and 10-14 years were responsible for 70% of the 189 unintentional injury deaths among those aged 0-14 (35% of the deaths each).

Unintentional Injury Deaths, Ages 15-24 years (E800-869, E880-929) Unintentional injury deaths account for 59% of all injury deaths in New Mexico for youth aged 15-24 and 53% of all deaths. 15-24 years olds lead any other age group of deaths from unintentional injuries.

Trend: Since 1979, the New Mexico rate has run higher but roughly parallel to the US rate. In 1997, the state rate of 49.55/100,000 was 36% higher than the United States rate of 36.4. Compared to other states, New Mexico has the highest unintentional injury death rate for all ages and has the 12th highest rate for youth aged 15-24. The state unintentional injury rate for youth aged 15-24 decreased dramatically between 1979 (111/100,000) and 1991 (61.83/100,000). Between 1991 to 1996 the rate has fluctuated but not significantly; in 1997 the rate dropped to 49.55.

Age: The 1995-1997 unintentional injury death rates are highest for young adults aged 20-24 (66.65/100,000), followed by youth aged 15-19 years old (51.22/100,000). Youth aged 15-19 was responsible for 236 deaths (47%), youth aged 20-24 were responsible for 211 deaths (53%).

Gender: The 1997 unintentional injury rate for males (70.18/100,000) is almost 2.5 times higher than the rate for females (28.17/100,000). The rates for males decreased dramatically between 1979 and 1992, and stabilized between 85 to 94/100,000 between 1992-1996, and dropped to 70.18 in 1997. The rates for females have been more stable, ranging between 22 to 41/100,000 during 1979-1997.
Race/Ethnicity: The 1995-1997 unintentional injury death rate for Native Americans (107.61/100,000) was 2.5 times higher than the rates for White, non-Hispanics (43.56/100,000). The rate for White, Hispanics (62.84) was 44% higher than the rate for White, non-Hispanics. The rate for African Americans (31.64) was 80% of the rate for White, non-Hispanics. The rate for Asian/PI is very low (16.6) as it is based on very few deaths.

County: The 1993-1997 unintentional injury death rates ranged from 215.23/100,000 in Sierra county (10 deaths) to 0 deaths in 4 counties. Eleven counties had 20 or more deaths. Seventeen of New Mexico's 33 counties had rates higher than the 1997 state rate of 49.55/100,000, and 24 counties had rates higher than the 1997 national rate of 36.4/100,000.

Motor Vehicle Crash Deaths: Motor vehicle crash deaths are the leading cause of death in this age group. The New Mexico rates are higher than the United States average and the state ranks in top 5 worst states. The CFR Transportation panel reviewed 80 of the 150 deaths in young people age 0-24 years from 1997. More than half of the deaths involved alcohol and non-use of seatbelts. Other issues identified were excessive speed, speed in an all terrain vehicle that has a high suspension and relatively narrow wheel base, use of go-carts on highways, and under-age drivers.

Firearm Fatalities: Firearm injuries in children and youth are a serious problem effecting youth with very high-risk circumstances. Of the 82 firearm deaths in youth <24 years of age in 1997, 38 were homicide; 41 were suicide and 3 were accidental or negligent gun use. A family gun was used in 59% of youth suicides; it was stored loaded, not locked and usually belonged to the father of the decedent. A vehicle, parking lots or the street was where 68% of firearm homicides occurred. Alcohol was present in 56% of firearm decedents; 33% were under age 18 and 58% under age 21. Both homicide and suicide victims have high rates of dropping out of school. Of firearm suicides, 78% had a prior arrest record.[82]

Youth Suicide: Youth suicide begins at an early age with rates increasing by age group: Age 10-14 , 13 deaths or 3.07/100,000; age 15-19, 65 deaths or 15.8/100,000; age 20-24, 92 deaths or 25.98/100,000.[83] A retrospective review of youth suicide for 1980-1996 revealed that New Mexico rates are twice the national rates for youth 10-14 (2.8 NM/1.4 US); 15-19 (20.0 NM/10.0 US) and 15-24 (~30.0 NM/ 15.0 US). The difference between race and ethnicity was negligible for Hispanics, Whites and American Indians. At autopsy, alcohol is a frequent finding (39-48%); drugs at 5% and the combination of drugs and alcohol at 6%. The method of suicide is largely firearms (68%); followed by hanging (17%), overdose (7%);

carbon monoxide poisoning (3%) and other causes (4%). As compared to older youth age 19-24, suicides in school age youth were more likely to occur in after school hours, at home and to involve firearms. [84]

10. Selected Dimensions Of Health For Youth In Transition, Ages 18-24

Youth in transition are of concern because they have low access to health insurance and relatively high health risk behavior prevalence. The New Mexico Behavioral Risk Factor Surveillance System (BRFSS) is an excellent source of data for this population. A summary of key findings from the 1997 BRFSS for youth age 18-24 follows (the 95% Confidence Interval is indicated in parentheses):

- 69.4% (CI 61, 77.8) have health care coverage
- 86.4% (CI 80, 92.7) had their blood pressure checked in the past two years
- 4.9% (CI 0.4, 9.4) was told that their blood pressure was high
- 15% ((CI 8.9, 21.2) self-reported height and weight is overweight based on Body Mass Index
- 35.9% said they had their blood cholesterol checked in the past 5 years
- None reported having diabetes
- 25.4% (CI 17.2, 33.6) reported seat belt use
- 22.9% (CI 15.4, 30.4) self reported as current smokers
- 26.8% (CI 17.6, 36.0) self reported as binge drinking in past month (5 or more drinks at one time)
- 3.9% (CI 0.6, 7.2) self reported drinking 60 or more drinks in past month
- 72.9% of females (CI 60.5, 85.3) self reported having had a Pap smear
- 70% of females (CI 57.5, 82.5) self reported a Pap smear in past 3 years

The prevalence of smoking (22.9%) in this group is remarkably lower than high school students who self report ~50% prevalence as current smoker in the same year.

11. Transition Services For Youth With Special Health Care Needs

As little as two decades ago, few children with severe illnesses or disabilities survived to adulthood. Today almost 90% of children with chronic conditions live to age 21 or beyond. An assessment was done of youth 19-24 who are in the period of transition, from being Medicaid eligible and in school to needing insurance and continued school or jobs. In 1998, it was estimated that the majority of the 300,000 students with severe disabilities who left high school that year were not able to live independently. Between 50-70% were placed in group homes and between 30-45% lived with relatives. Only 12% of Americans aged 16-64 with severe disabilities were employed.
This needs assessment of transition services reviewed:

- transition-related services offered by and challenges faced by New Mexico state agencies, commissions, and organizations
- medical transition and challenges faced by adolescents during transition in the University of New Mexico Health Sciences and the Indian Health Service systems
- income support and Medicaid coverage for youth with special health care needs in New Mexico
- the perceptions of youth with special health care needs and their families in the areas of medical transition and their preparation for independent living and a career.

The major findings of the study by area are:

Primary and Specialty Medical Care

- There is a lack of formal, comprehensive, coordinated medical transition planning in New Mexico
- Medical practitioners appear largely unaware of the range of transition planning that would be beneficial and their role in transition planning.
- Adult practitioners who work with special needs youth and their staff might benefit from additional training in the issues associated with adolescent development, the importance of considering the youth in the context of their family and their cultural heritage, and in working with special needs patients
- Special needs youth and their families would benefit from more education in the inherent differences between pediatric and adult-centered care and advance preparation for the transition to an adult provider.
- Youth and their families would benefit from more family-centered care that supports both the family as a whole and the individuals within the family as independent entities.

Mental Health Care

- There is a need for greater access to behavioral health services, both for youth with special health care needs and for their families.
- Specialty mental health care (e.g., for the developmentally disabled, for multiply diagnosed patients, and for youth convicted of crimes, especially sex offences) is difficult to obtain.
- Behavioral health care service delivery under managed care systems may not adequately meet the needs of all special needs youth.
- There is a shortage of treatment foster care programs.
- Mental health diagnoses and service eligibility criteria differ for child- and adult-oriented services, making service continuity a challenge.

Vocational Goals

- Youth with special health care needs are less likely than their non-disabled peers to be employed or pursue postsecondary education.
- Youth, their families, and teachers need more information on the importance of student-led, comprehensive, outcome-oriented transition planning that begins years before the youth exits the school system and is updated on a regular basis to reflect the youth's progress and current interests.
- Youth, their families, and teachers need more information on the key elements of a comprehensive transition plan.
- Youth and their families need more information about vocational and postsecondary educational options in their area.
- There is a need for statewide consistency in transition planning and transition services.

Economic Considerations

- Many youth with special health care needs require the support of publicly funded financial assistance and insurance programs. Because eligibility requirements change at 18 (Supplemental Security Income) or 19 (Medicaid), youth transitioning to adulthood may become ineligible for vital financial/insurance/housing support but not be able to achieve financial security independently. On the other hand, if an individual achieves substantive employment, they will likely become ineligible for subsidized housing and/or SSI (and thus Medicaid), yet most employer-based medical insurance policies will not cover pre-existing conditions.
- Because of the labyrinthine eligibility requirements, policies, and procedures of financial assistance programs for the disabled, there is a great deal of confusion and ignorance of the programs and any associated work incentives.
- Waiting lists for services (e.g., waivers, public housing) are lengthy, and transition planning must begin years in advance of the anticipated need for services.

Legal Considerations

- Greater awareness of disability legislation in the community at large.
- Parents and youth need training on the legal aspects of the youth's reaching 18.
- Youth with special health care need education on the rights and responsibilities of adulthood.

Living Arrangements

- Youth with special health care needs face significant barriers to independent living: there is a shortage of affordable housing for those able to live independently, and a shortage of semi-independent, group, and supported living opportunities for those who are not.
- Certain populations of special needs youth (e.g., youth with a history of violence or sexual offence) have virtually no opportunity for independent living in a supported setting.
- Youth exiting protective custody have extremely limited housing options.

Life Skills

- Youth with special health care concerns need more training in accepting responsibility for self-care; self-advocacy and self-determination skills; social skills, including personal safety; and competency in the responsibilities of daily living.
- There is a need for positive role models and mentoring in the lives of youth in protective custody.
- Family training in helping the youth achieve independence in their daily activities may facilitate transition.
- Communications skills training may benefit both youth with special health care needs and their families.
- A lack of viable transportation options often confounds the vocational, independent living, and social goals of youth with special health care needs.

Social Life

- The importance of social/recreational activities and community involvement in the lives of youth with special health care needs is often overlooked.
- Youth in protective custody may lack social opportunities integral to healthy development (e.g., relationships with mentors/supportive adults, recreational and leisure activities).
- Disability awareness and sensitivity in American society is low.

Cultural Considerations

- The youth's cultural heritage is not always considered in the planning of services and transitions, which may affect efficacy.

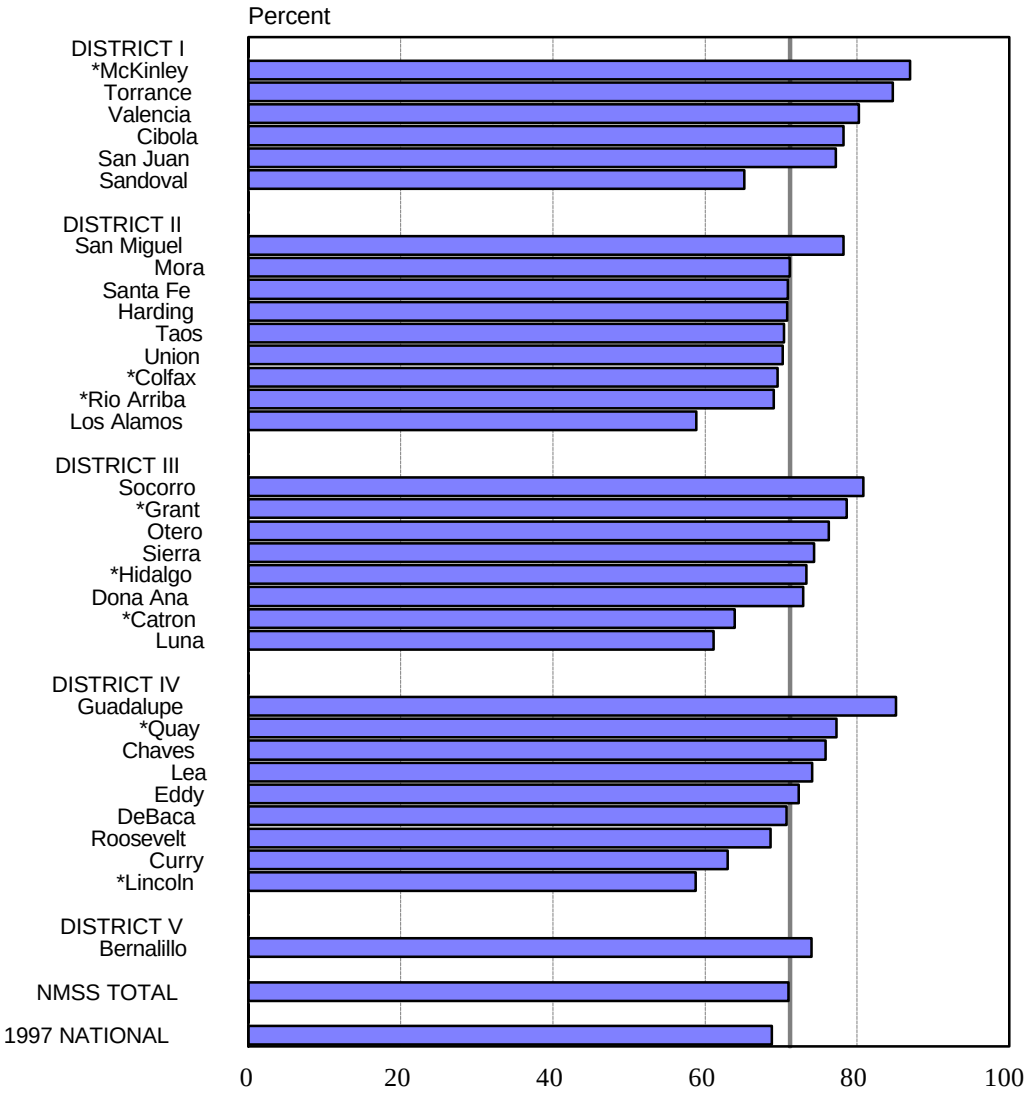
Service Coordination and Continuity

- The highly rural and culturally diverse nature of New Mexico can cause challenges to service delivery, coordination, and continuity.
- There is a lack of communication/collaboration/networking among families/agencies/providers/schools/community/business in the coordination and planning of services to youth with special health care needs.
- Youth with special health care needs may require, but may not receive, a comprehensive array of coordinated services.
- Continuity of care is a tremendous challenge for many reasons, systemic and individual.
- There is a need for standardized terminology in describing conditions and behaviors both between youth and adult systems and among agencies.
- There is a need for cross-training among agencies serving children and adults to ensure service continuity for youth with special health care needs.
- A lifespan, interdisciplinary, person-centered approach to transition is needed.

District and county level comparisons for selected measures for the teen population issues are illustrated in the following graphics:

Alcohol Use and Teens

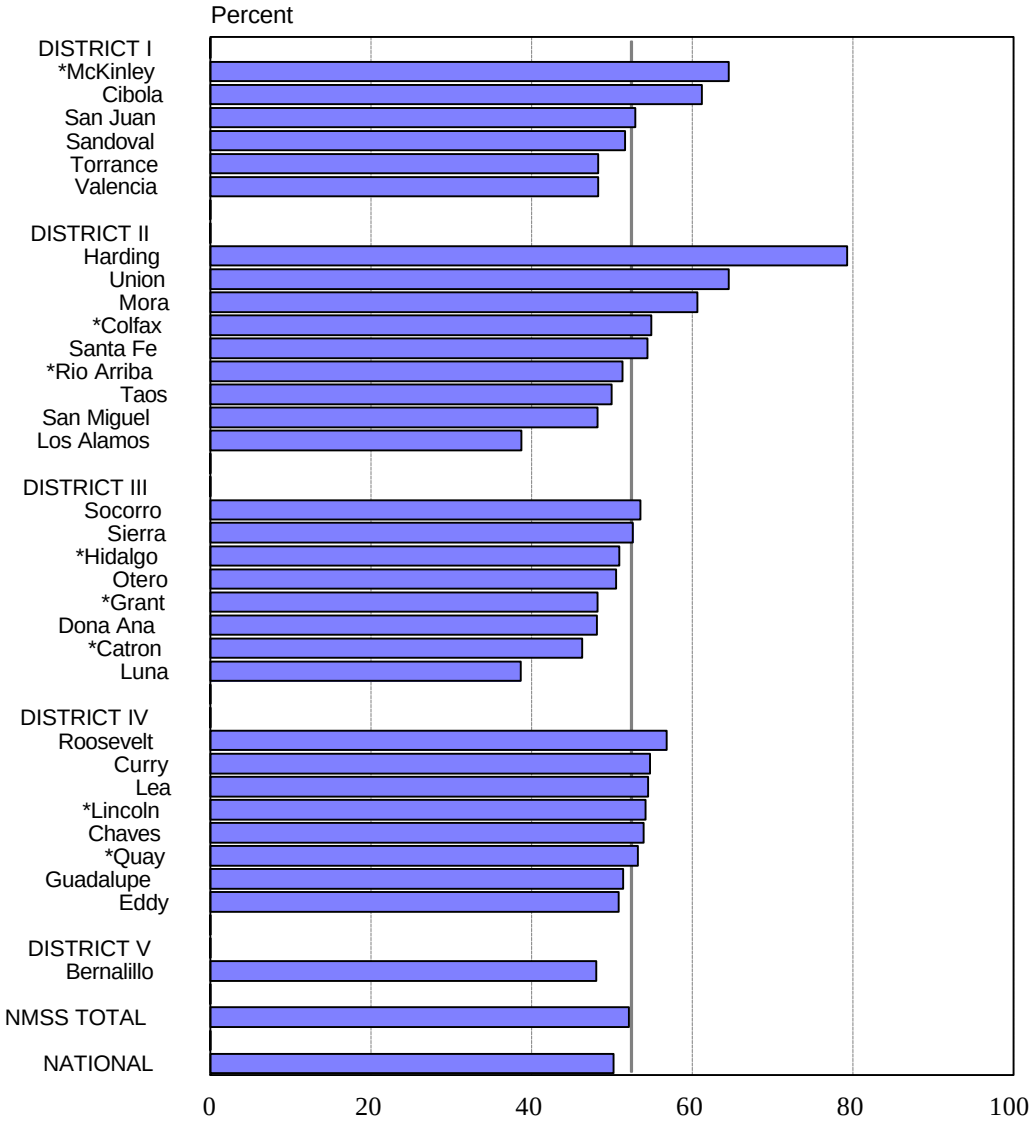
Figure 24. Rates of Past Year Alcohol Use
by County and Health Planning District, Grades 9-12, 1997



*Counties with partial representation in the New Mexico School Survey
Source: Office of Epidemiology, New Mexico Department of Health

Tobacco Use and Teens

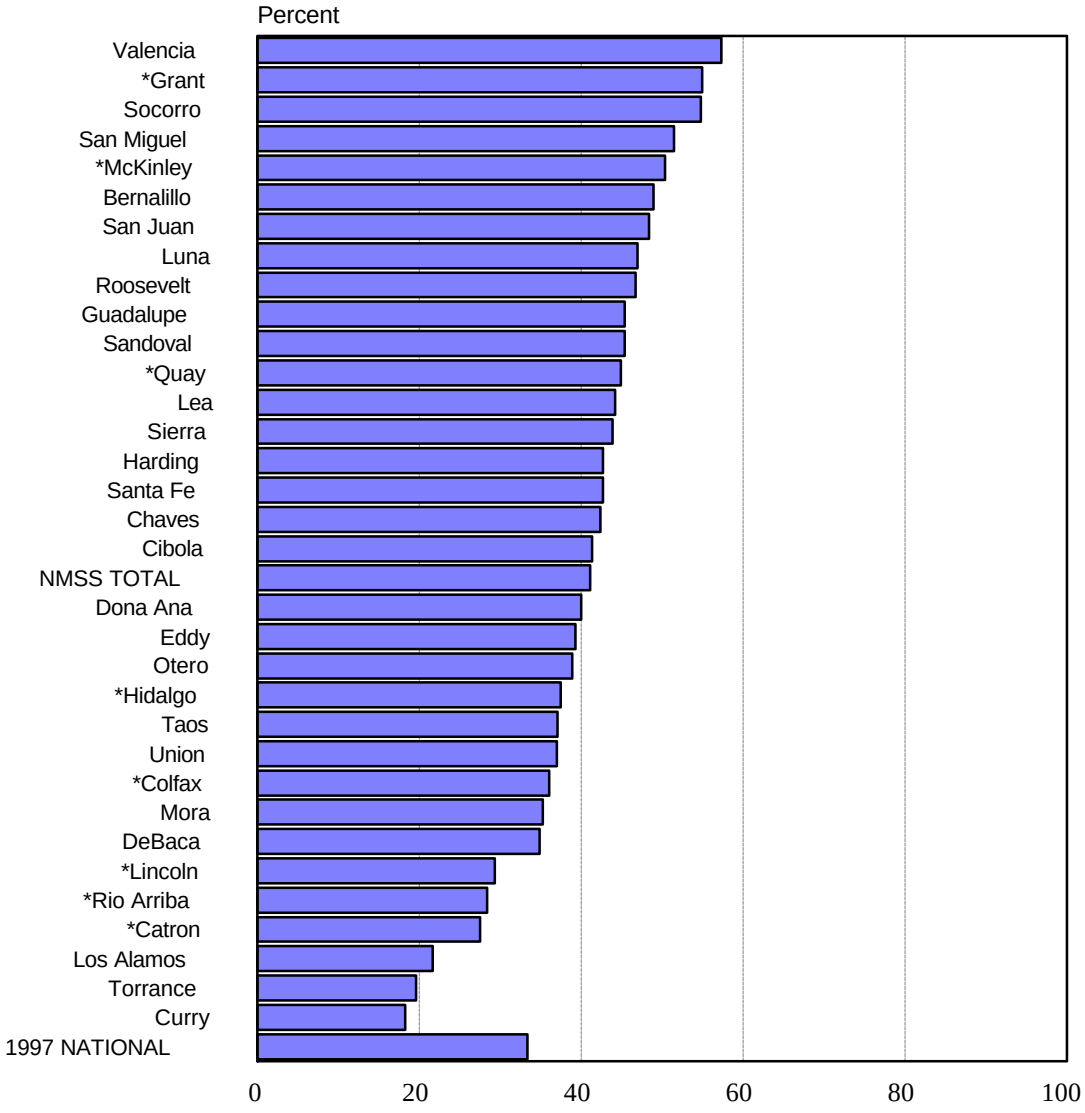
Figure 26. Rates of Past Year Cigarette Use
by County and Health Planning District, Grades 9-12, 1997



*Counties with partial representation in the New Mexico School Survey
Source: Office of Epidemiology, New Mexico Department of Health

Marijuana Use

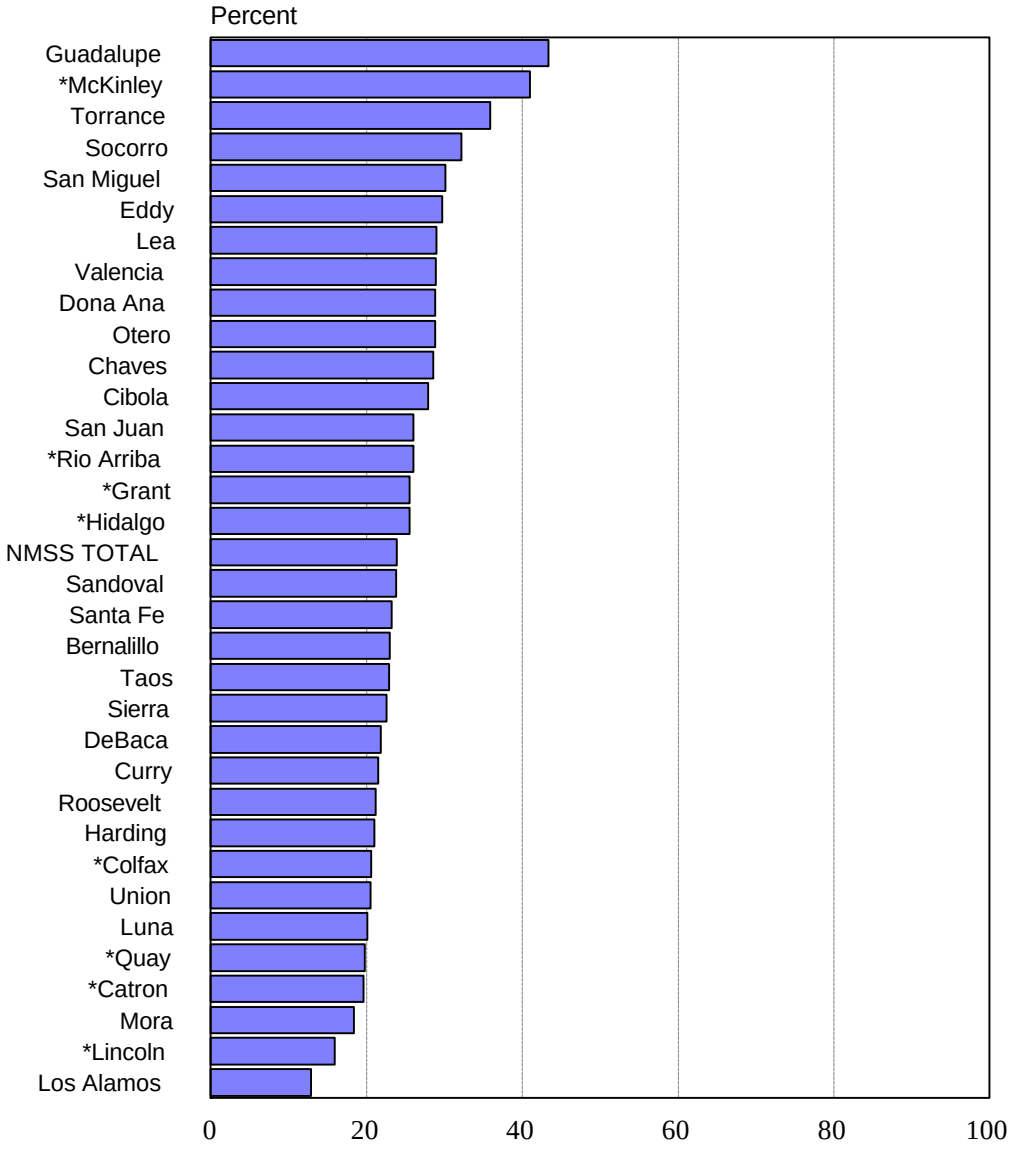
Figure 27. Rates of Past Year Marijuana Use by County
Grades 9 - 12, 1997



*Counties with partial representation in the New Mexico School Survey
Source: Office of Epidemiology, New Mexico Department of Health

Driving While Intoxicated

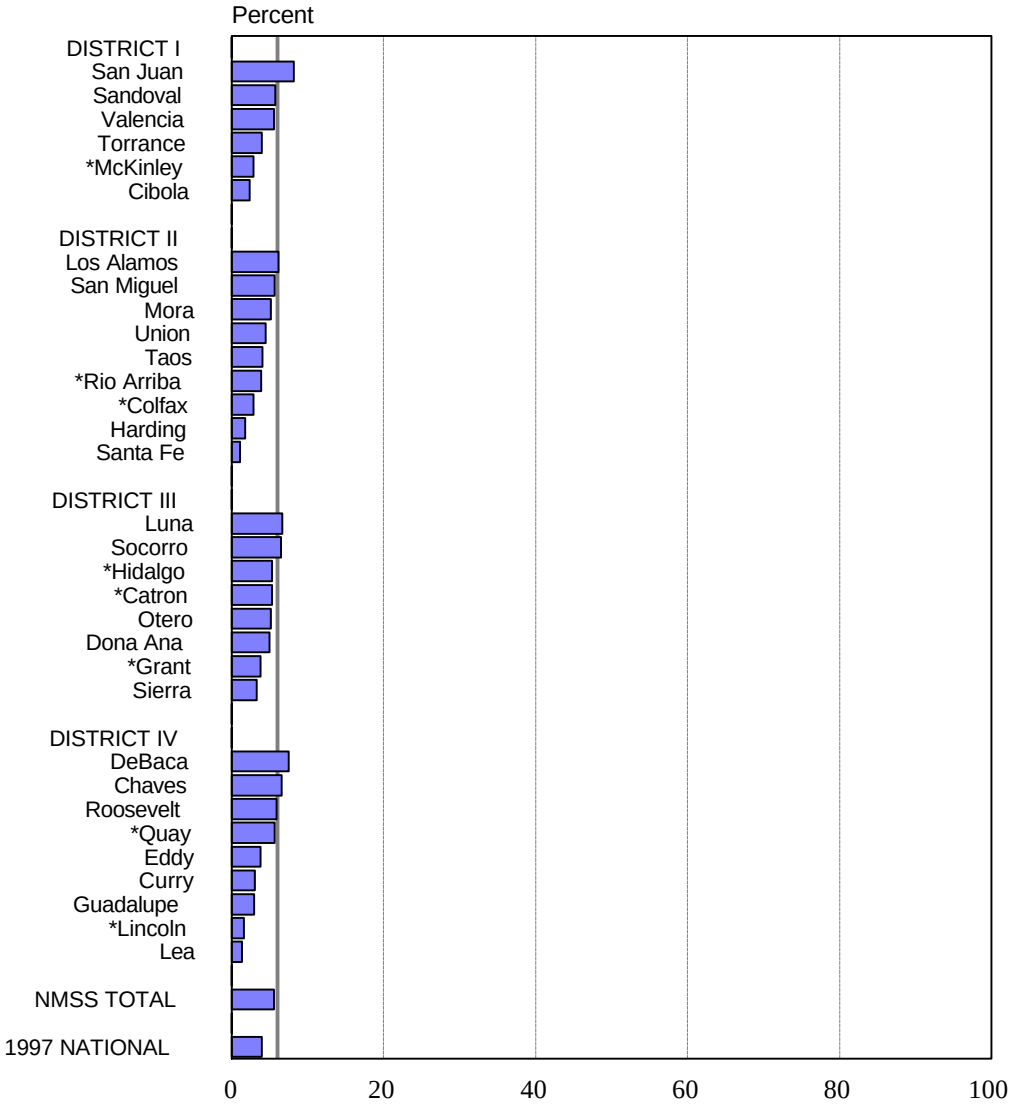
Figure 29. Rates of Reported Drinking & Driving
Past Year, by County, Grades 9 - 12, 1997



*Counties with partial representation in the New Mexico School Survey
Source: Office of Epidemiology, New Mexico Department of Health

Safety Issues and Teens

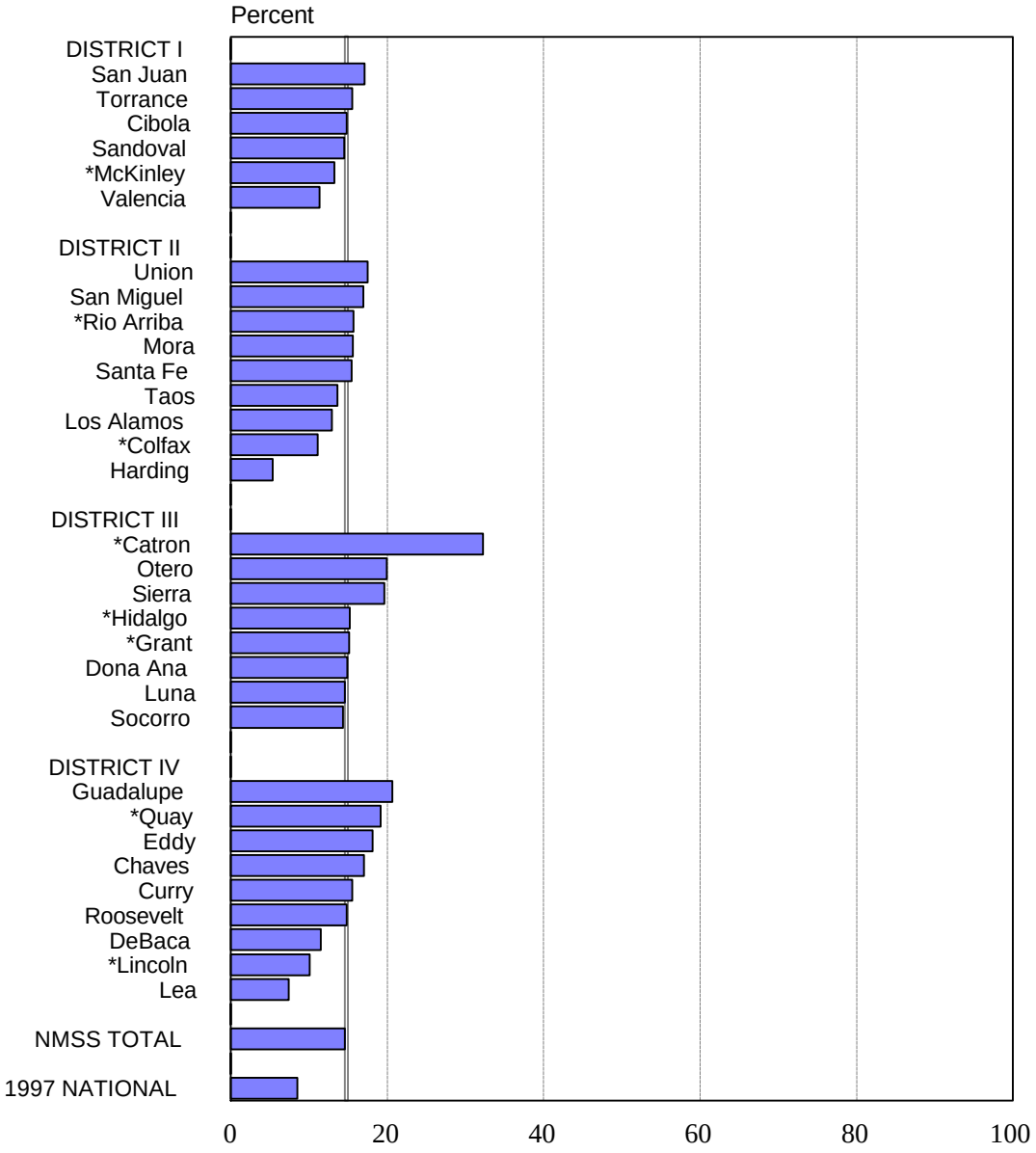
Figure 38. Rates of Missing School Due to Feeling Unsafe Past Month by County and Health Planning District, Grades 9-12, 1997



*Counties with partial representation in the New Mexico School Survey; no data for Bernalillo County
Source: Office of Epidemiology, New Mexico Department of Health

Weapons and Teens

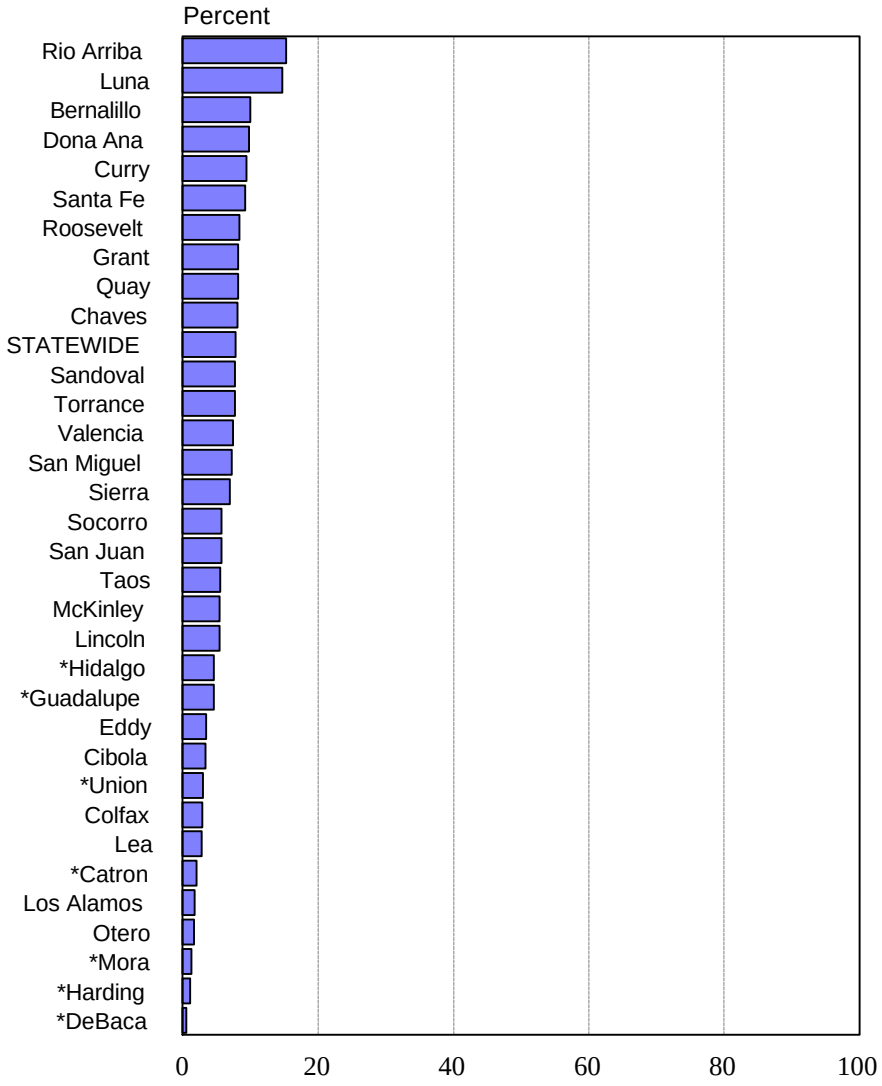
Figure 40. Rates of Carrying Weapons to School Past Month
by County and Health Planning District, Grades 9-12, 1997



*Counties with partial representation in the New Mexico School Survey; no data for Bernalillo County
Source: Office of Epidemiology, New Mexico Department of Health

High School Dropout Rate in New Mexico [85]

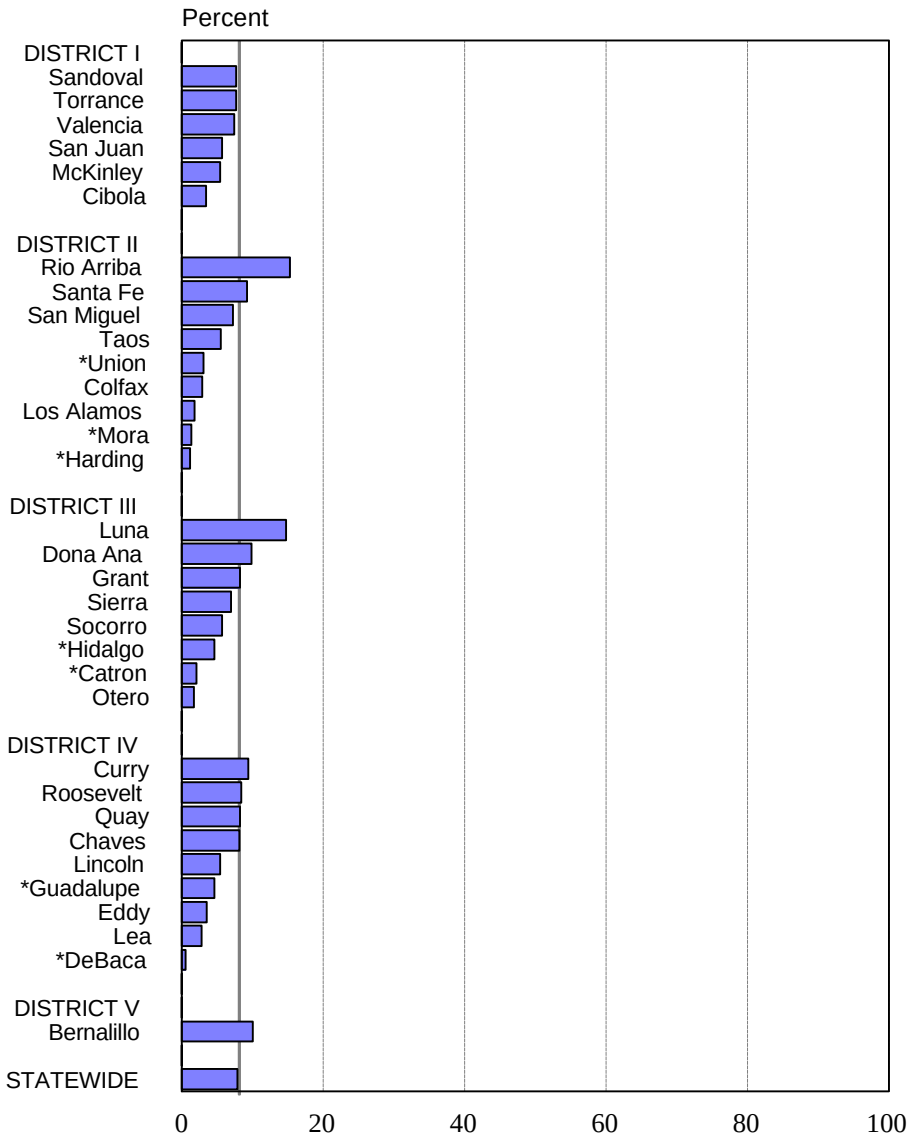
Figure 21. Rates of High School Dropout by County, 1995/96 -1997/98 Average



*Counties with population <10,000
Source: New Mexico Department of Education

High School Dropout Rate in New Mexico

Figure 22. Rates of High School Dropout by County and Health Planning District, 1995/96 -19997/98 Average



*Counties with population <10,000
Source: New Mexico Department of Education

3.1.2.2 Direct Health Care Services

A gap continues to exist for children who are eligible for enrollment, not eligible for Medicaid, and are unable to access the HKF program. Over 16,000 children were referred to Medicaid during FY 99. CMS administers the Healthier Kids Fund (HKF) Program. The fund was closed to new enrollees in January of 1999 due to budget restrictions. A grassroots effort was made by advocates and legislators to ensure adequate funding for all in need, however, the bill was not passed by the legislature.

During this past year, 13,111 children, ages 3-19 years, with no other payment source were served by the HKF program. The children and families served by the Healthier Kids Fund Program receive minimal service coordination and interpretation services, but little else in the way of enabling services because of the budget limitations.

3.1.2.3 Enabling Services

Issues specific to New Mexico access to health services. These issues include:

a. Insurance Coverage: Seventeen percent of New Mexican children under the age of 18 have no health care coverage compared to 15.4% nationally.[86] Of insured children, 59.3% of children under 18 are covered through parental employee-based insurance and 25.5% through Medicaid. Recent statistics also show that 60% of women of childbearing age are covered with 49% of pregnant women covered through private insurance and >45% covered by Medicaid. Gaps and disparities related to insurance coverage include family income as a proportion of the federal poverty level, race/ethnicity, and geography.

According to the US Census, the trend of insurance coverage in New Mexico from 1990 through 1998 is improving. New Mexico children under 18 had an uninsured prevalence of 17.1% (representing about 97,000 New Mexicans) in 1998, down from 20.1% in 1997 and 22% in 1990. This is compared to the national percentage of uninsured children at 15.4% in 1998. With regards to the type of coverage used, the largest source for New Mexico children has consistently been through parental employee-based insurance, with 59.3% of children insured in 1998. Employment based coverage increased 9.4% from a 1997 figure of 49.9%, accounting for the overall increase in health insurance coverage for New Mexico children in 1998.

The second most common insurance coverage has consistently been through Medicaid (25.5% in 1998) and the smallest sources of coverage have been through private non-employment based insurance and the federal/Military employee programs (2%, and 2.3% respectively in 1998). Medicare has covered a small portion of New Mexico children and has increased slightly from 0.5% in 1990 to 1.6% in 1998.

The available data presented demonstrates economic disparities in New Mexico and its influence on health care coverage for children. Although a large portion of New Mexico children are covered through parental employment-based insurance (59.3%), approximately a quarter of children are covered through Medicaid (25.5%). Given the income requirements for qualification, a large portion of children in New Mexico live under economic difficulties. Seventeen percent of children in New Mexico have no

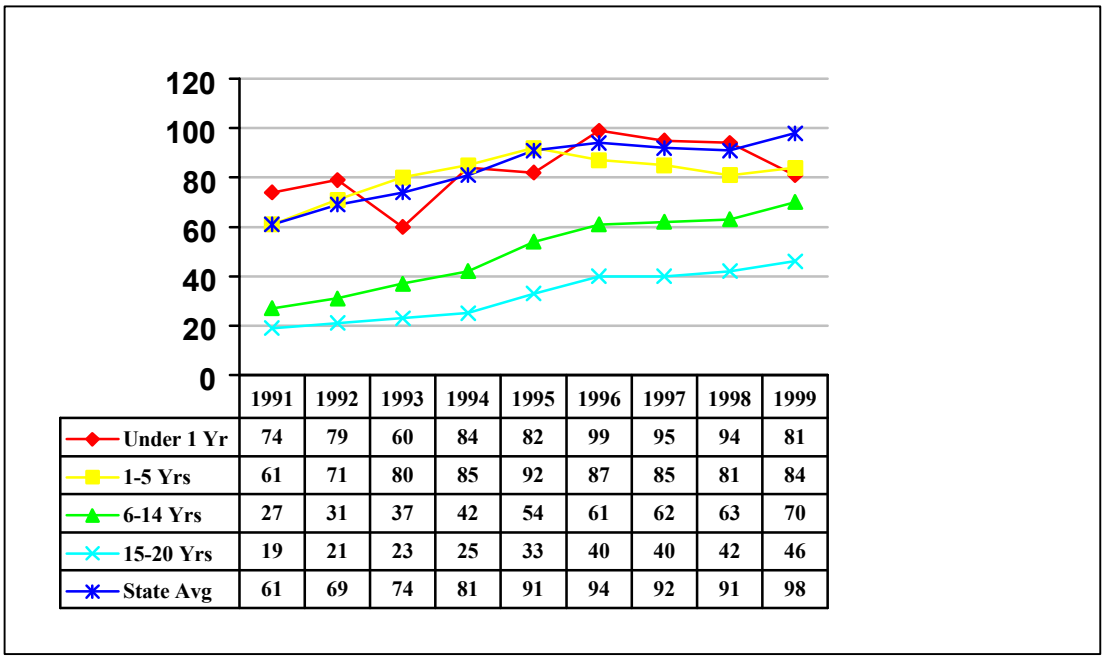
health care coverage and 40% of women of childbearing age are uninsured. Among recently pregnant women, 44% were covered all or in part by Medicaid. The following conditions are a source of concern and need to be examined:

- **Federal Poverty Level:** Children living in families whose income is 100% or less of the federal poverty level are more likely to be uninsured (17%) compared to those living at 101-185% (15.1%), those at 186-235% (8%), and those over 235% the federal poverty level (3%).
- **Geographical Environment:** Although somewhat arbitrary in design, the New Mexico Public Use Microdata Areas reflect economic differences in geographical pockets and, consequently, levels of insurance coverage. In particular, high levels of uninsured children (16.6%) are located in PUMA 100 in the northwest corner of New Mexico. This region is a rural, largely Navajo area and is troublesome given the availability of coverage Medicaid and the Indian Health Service. Conversely, more affluent areas surrounding Bernalillo County (Albuquerque) report less uninsured children (4.3% for PUMA 300).
- **Race and Ethnicity:** Differences between Hispanic and non-Hispanic New Mexicans are evident with approximately 37% of Hispanic children uninsured compared to 13% of Non-Hispanics.[87]

b. Health Maintenance Organization (HMO) penetration is higher in New Mexico (38.1%) than in the Nation (34.2%). Profitability for the HMO is low with negative profit margins reported nationally in 1999. In New Mexico, the average operating profit margin was –2.7%; range +3.4% to –17.5%. The state Medicaid Managed Care Organization (MCO) enrollment for the three plans offered nearly doubled from June 30 1997 to June 30, 1998 increasing from 40% to 79.4%. In 1998, the New Mexico proportion was nearly one-third greater than the US Medicaid MCO enrolment of 53.6%. [88]

c. Medicaid: The Medicaid population in New Mexico was assessed for access to and use of Medicaid services for children age 0-20 years based on the HCFA 2082 data reports submitted by the Human Services Department to HCFA. The estimate of the ratio of eligibles (children with a Medicaid card) to potential eligibles (population <185% of FPL) increased from 35.7% in 1991 to 66.8% in 1999. One may conjecture that this may be a function of increased outreach. Crowding out (parents going onto Medicaid from private insurance) is not known.

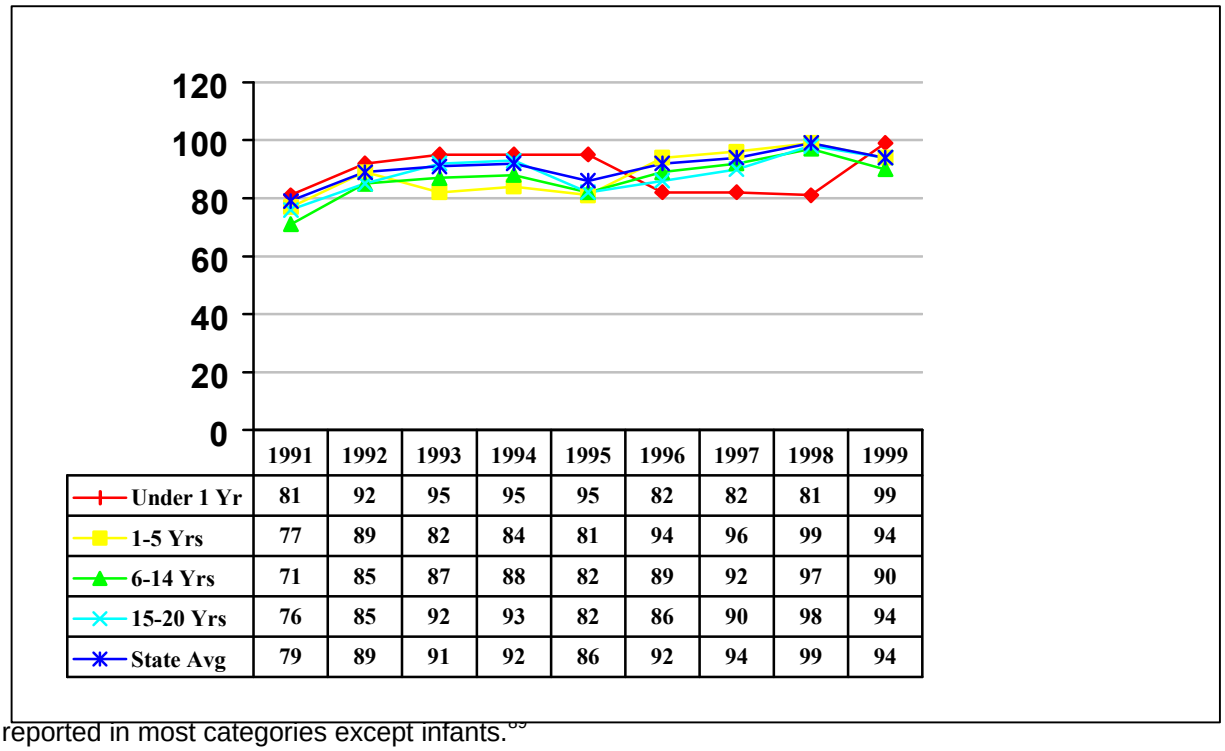
Figure 1: Ratio of Medicaid Eligibles to Potential Eligibles by Age Groups, New Mexico 1991-1999



	1991	1992	1993	1994	1995	1996	1997	1998	1999
Under 1 Yr	74	79	60	84	82	99	95	94	81
1-5 Yrs	61	71	80	85	92	87	85	81	84
6-14 Yrs	27	31	37	42	54	61	62	63	70
15-20 Yrs	19	21	23	25	33	40	40	42	46
State Avg	61	69	74	81	91	94	92	91	98

The estimate of the ratio of recipients (those who received at least one service billed to Medicaid) to eligibles appeared to have increased from 75% in 1991 to 94.6%in 1999. This is appears to be a data artifact due to billing and reporting by capitation under Managed Care with recipients approximating eligibles. Data based on recipients cannot be used because of many errors found thoughout the report.

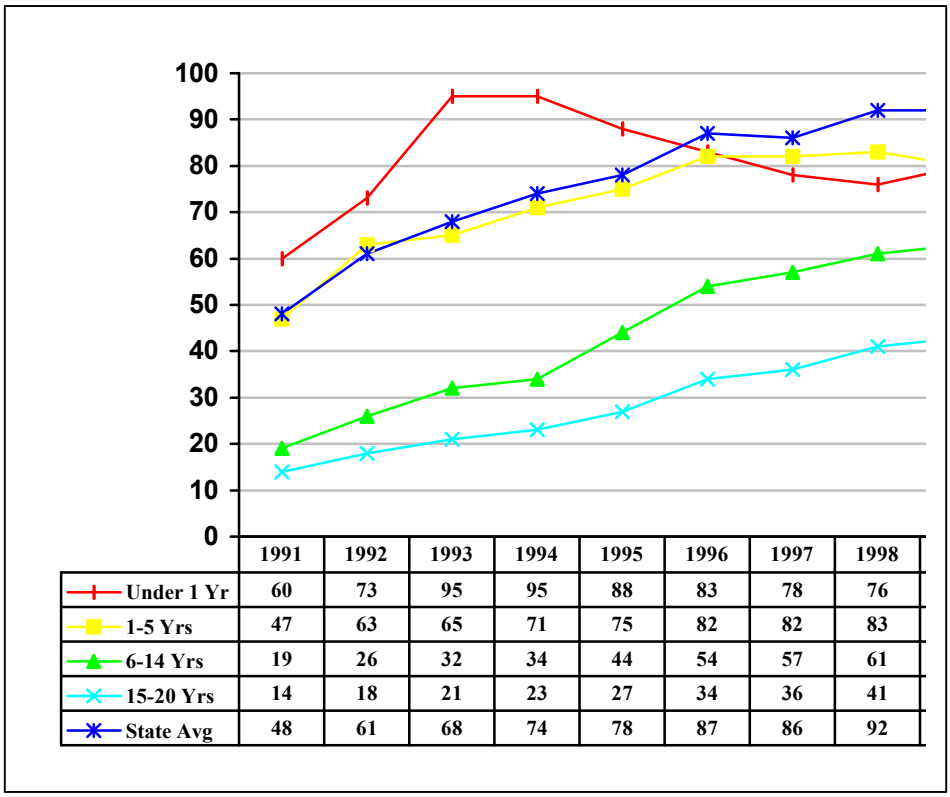
Figure 2: The Ratio of Medicaid Recipients to Eligibles, by Age Group, 1991-1999



	1991	1992	1993	1994	1995	1996	1997	1998	1999
Under 1 Yr	81	92	95	95	95	82	82	81	99
1-5 Yrs	77	89	82	84	81	94	96	99	94
6-14 Yrs	71	85	87	88	82	89	92	97	90
15-20 Yrs	76	85	92	93	82	86	90	98	94
State Avg	79	89	91	92	86	92	94	99	94

reported in most categories except infants.[89]

Figure 3: The Medicaid Ratio of Recipients to Census Estimate of Potential Eligibles



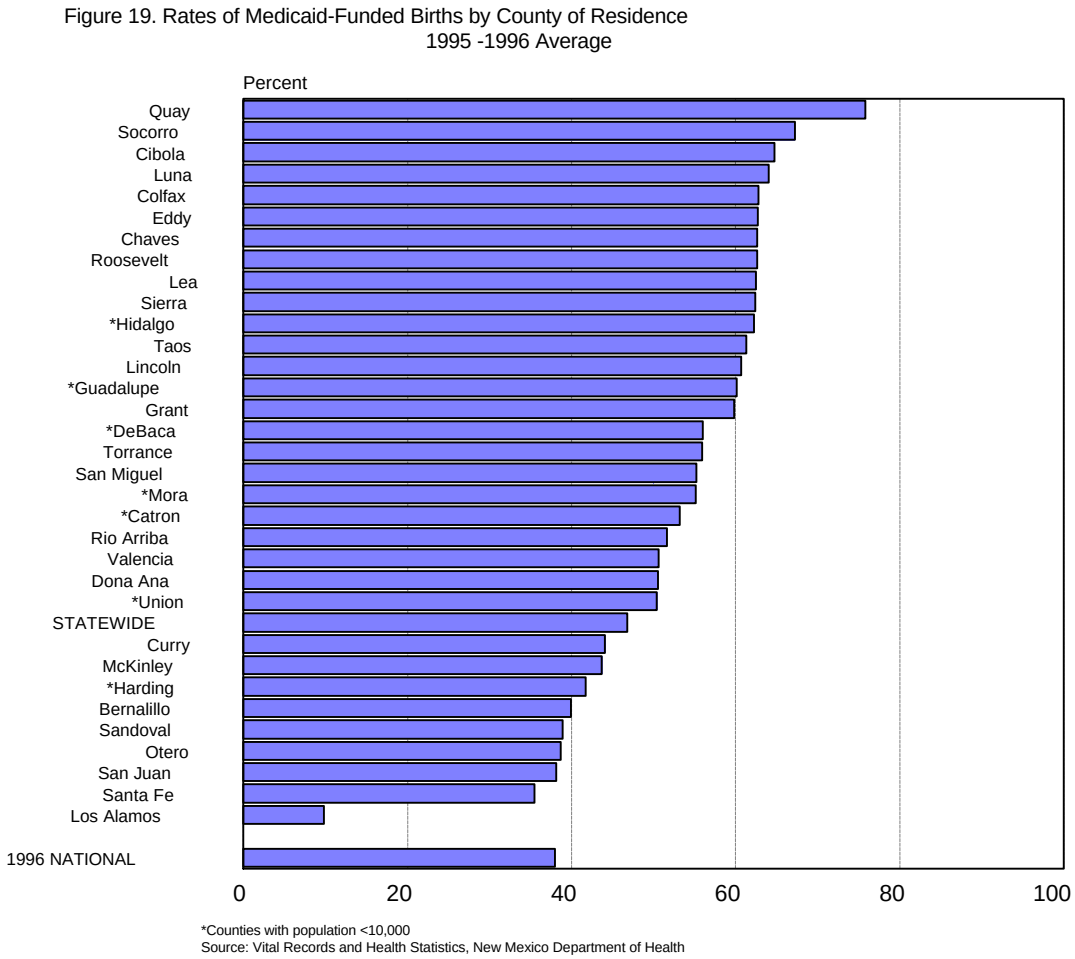
	1991	1992	1993	1994	1995	1996	1997	1998
Under 1 Yr	60	73	95	95	88	83	78	76
1-5 Yrs	47	63	65	71	75	82	82	83
6-14 Yrs	19	26	32	34	44	54	57	61
15-20 Yrs	14	18	21	23	27	34	36	41
State Avg	48	61	68	74	78	87	86	92

Table 1: The Medicaid Population in New Mexico: Summary of Access to and Use of Medicaid Services from 1991-1998, Based on NM HCFA 2082 Documentation

Data Description	1991	1992	1993	1994	1995	1996	1997	1998	1999
Population <20	529,403	540,244	554,728	564,586	572,250	575933	580,257	580,257	580,257
Potential Eligibles <20 Yr.	338,817	345,756	355,025	361,335	366,240	368,597	371,364	371,364	371,364
Eligibles <20 Yr.	121,052	122,369	158,800	178,960	214,555	224,007	224,380	225,236	248,181
Recipients <20 Yrs	90,924	104,453	145,684	160,622	165,677	209,156	214,928	222,224	234,767
Ratio of Eligibles to Potential Eligibles	35.7%	40.6%	44.7%	49.5%	58.6%	60.8%	60.4%	60.7%	66.8%
Ratio of Recipients to Eligibles	*75.1%*	*87.3%*	*85.5%*	*87.4%*	*82.4%*	*88.9%*	*92.3%*	*94.1%*	*94.6%*
Ratio of Recipients to Potential Eligibles	*26.8%*	*35.5%*	*38.3%*	*43.3%*	*48.4%*	*54.0%*	*55.8%*	*57.1%*	*63.2%*

Medicaid Coverage for Births: In 1996, Medicaid paid for an estimated 46.8% of births as compared to the national figure of 38%. The range among counties varied from 9.8% in the most affluent county to 75.8% in a poor, rural county.[90]

Figure 4: Medicaid Coverage of Births in New Mexico



Impact of Medicaid Managed Care and Status of Medical Home Concept, Children with Special Health Care Needs: A telephone survey of a sample of CMS children, a Focus Group interview with 11 volunteer parent counselors and a Focus Group interview with 8 providers in a Pediatric Clinic were conducted in Dona Ana County to assess health dimensions.[91] Key findings are summarized here.

Characteristics of survey respondents: 290 adults were contacted of whom 74% were mothers, 15% fathers, 6% grandmothers and 5% other care givers. 39% had less than a high school education. Spanish was spoken at home by 25% of families that may serve as a proxy for immigrant families.

Characteristics of children about whom the survey inquired: 11% were age 0-3; 13% wer age 4-6; 28% were age 7-12; 46% were age 13-21; and 2% were $21 years; 47% were male and 53% female; 72% were of Hispanic, Latino or Mexican descent; and 27% were white non-Hispanic, only 1% were African American.

Health care payment sources were 50% Medicaid, 16% used a free clinic or sliding fee scale; 9% had private health insurance; and 2% paid with cash. The CMS program covered services for 81% of children.
Medical Conditions The most common condition reported was asthma by 69% of respondents; followed by heart condition in 15%; epilepsy, developmental delay and cleft palate at 14% each; seizure disorder 8%; otitis media and allergies at 7% each.
Medical Home Concepts: 90% reported having a Primary Care Provider; 46% saw the PCP in past 6 months; 82% said the PCP was respectful of their concerns for the child; 79% said they could get appointments when needed. Written communications and information sharing reached only 25% of respondents; 45% reported getting reminder appointment cards; 47% said their PCP and early intervention or care coordinator worked together to serve them. Improving systems for service coordination and education would overcome many obstacles to achieving a Medical Home.
Impact of Medicaid Managed Care (Salud!) An estimated 10% of respondents reported a negative impact, lowering their opinion on the 10-point scale or changing MCO to get preferred doctor. The latter is a parent's effort to preserve a Medical Home for a child. Medications and access to dental care continue to be issues as in years past.
Parent Volunteer Counselors Focus Group Findings: As in years past, the Human Services Department case workers were reported to be rude; other issues were related to unmet expectations regarding selected services and various red-tape kinds of issues.
Provider Focus Group Findings: With MCO arrangements, some forms were simplified, case management serves children with complicated conditions and it seems more people are on Salud than on the old Medicaid. Prompt management of enrolment and eligibility, data completeness for client care, formulary, and assignments to HMO or PCP were problem areas.

Children's Medical Home Provider Survey: A survey of Medical Home Practice Standards was sent out to 400 physicians in New Mexico. With a 52% response rate, the majority (74%) said they would be interested in training about the Medical Home concept. The results are summarized in the table below:

Table 2: New Mexico Physicians and the Medical Home Concept

Medical Home Concepts	Strengths in Practices	Weaknesses or Gaps to Close
Accessibility	Available 24/7 if needed Payment options Client can speak directly w/MD	Few evening and weekend appointments are available
Family Centered	Families participate in decisions Collaborative relationship Explores all options for child Acknowledges parent expertise	Help families use coping strategies
Comprehensive	Primary care and prevention provided Schedule extra time for CSHCN Refer families to non-medical services	Links families to support services Provides information on $ resources
Continuous	Ages 0-24 seen in one practice	Meet with discharge planner Aware of and helps parents through transition points
Coordinated	Refers if needed to pediatric sub-specialists, mental health specialists Practice has central record of child's information	Participates in IFSP or IEP Medical care plan is shared with other providers
Compassionate, culturally competent	Respects sociocultural values and beliefs of families A translator or interpreter is provided	Materials distributed translated in primary language of family Asks about family beliefs to include in a treatment plan

3.1.2.4 Population-Based Services

Teen Pregnancy Prevention: *Challenge 2005: Reducing Teen Pregnancy in New Mexico* provides teen birth data for age group 15-19 by county showing related data and a compilation of programs dedicated to reducing teen pregnancy. Each county page features the number of teen births to be averted/prevented between 2001-2005 in order to achieve a 20% reduction in rate; teen birth rates for past 5 years; selected demographics such as [race-ethnicity, percent children in poverty and grade 9-12 drop out rates along with a listing of active programs according to 13 program types.[92] According to this report, country teen birth rates ranged from 19.4 to 106.6/1,000 population in 1998. There were a total of 272 program sites in the state. Counties with 10 or more program sites are listed here

Table 3: Teen Pregnancy in New Mexico, Per County 1998

County	Teen Pregnancy Rate	Target Programs
Santa Fe County	51.5/1000	41
Sandoval County	53.7/1000	14
Bernalillo County	62.7/1000	39
Grant County	68.8/1000	12
Dona Ana County	65.8/1000	22
Rio Arriba County	86.8/1000	12
Chavez County	93.7/1000	16
San Juan County	71.2/1000	10

The remaining 25 counties had rates of 19.4 to 106.6 births per 1,000 teens age 15-19 and had from 1-9 program sites. By population size and burden of teen pregnancy, Eddy and Lea Counties with teen birth rates over 100 had only 5 program sites. The resource listing did not indicate coverage of the teen population or sub-populations by county, thus coverage is difficult to assess.

3.1.2.5 Infrastructure Building Services

Medicaid/Salud! Human Services Division: Considerable effort has been made by CMS/PHD and advocates in this fiscal year to impact the Medicaid RFP process for the SALUD managed care organizations. Of special interest is input regarding CSHCN including a definition of CSHCN and recommended purchasing specifications that address the CSHCN population. *Purchasing Medicaid Managed Care for Children with Special Health Care Needs,* a technical assistance document, prepared by George Washington University Center for Health Services Research and policy (CHSRP) in consultation with HCFA, HRSA, and SAMSHA was utilized for guidance. Ongoing collaboration is needed to continue to identify gaps in service and service needs for CSHCN.

Social Security Income (SSI) Advocates and CMS collaborate with CMS providing partial funding for the coordinator of the working group. Efforts are continually being made to inform families whose children have been denied SSI benefits as well as those who have been approved. Meetings are held quarterly with SSA, Disability Determination Services (DDS), and CMS. In addition, CMS continues to work with Shriner's Hospital in Los Angeles, Salt Lake City, and Houston to ensure follow-up service coordination.

Vocation Rehabition Division and CMS collaborated this year to educate CMS staff about transition issues and access to services.

The LEND Program of the University Affiliated Program (UAP) at the University of New Mexico and The Title V Program have partnered to bring MCH grantees together bi-monthly (MCH Collaboration) to share information, learn about the progress of the grants, and to develop strategies for moving towards a seamless, comprehensive service system. The MCH Collaborative worked with the CMS program in the development of Medical Home Providers' Survey, and will utilize this information to develop medical home training for providers in New Mexico.

CMS Staff, Providers, Parents Reaching Out and Family Voices Advocates, coupled with MCH Collaborative representatives worked together to assist CMS in a Cultural Competence Self-Assessment through Georgetown University.

The Double Rainbow Project funded by MCH and administered by Southwest Communication Resources, Inc. in Bernalillo (Sandoval County) is supported by CMS. This project brings together the MCO's, providers, early intervention programs, physicians, state agencies such as the Human Services (administers the MCO contracts), Income Support, and CMS, community agencies, and families of CSHCN to discuss how children eligible for IDEA, Part C services will be served. Children with developmental disabilities are currently carved out of Medicaid Managed Care for their early intervention services, but are covered for medical services. This project has facilitated great information sharing so far and recently completed a survey exploring managed care and medical home issues.

Head Start Projects: CMS provides consultation to Head Start projects re: nutritional services and children's medical care options.

Community Integrated Service Project (CISP) is a Head Start grant to coordinate services with community agencies, transition children to school, and assist parents return to work. The Family Health Bureau has provided technical assistance and state support for the project. The State Office and District CMS Nutritionists are building systems of nutrition services through screenings, referrals, and training for providers, CMS staff, families, parent advocates, and other community programs, i.e. Head Start. Nutrition Partnership is a group consisting of parents, providers, and agency staff who meet regularly to address gaps and barriers to develop a seamless system of nutrition services. Lack of Medicaid reimbursement for nutrition services creates serious access problems.

Special Issues with CSHCN

Standards of Care for CSHCN: New Mexico will adopt standards of care for CSHCN when such national standards are developed. At this time, New Mexico does not have the capacity to monitor continuous quality improvement. Through the front line efforts of social workers within CMS, an ongoing awareness is gained about the availability and quality of community-based services.

State Tax Policy and Children in Poverty: The New Mexico Advocates for Children and Families (NMACF) did an analysis of the state law that effects low income families and allows them to receive a rebate derived from gross receipt sales on food and other commodities. Based on this study, the NMACF published a white paper on proposed tax structures to further relieve families living in poverty….

The Office of Information Management (OIM) and the PHD are developing an integrated client data system that would meet federal and state level reporting needs for:

1) services to clients by selected demographic, diagnosis and eligibility criteria;
2) billing of services to Medicaid Managed Care Organizations; and
3) client services tracking for ensuring quality care in local health offices.

In the first phase, over 200 PHD clerical and clinical staff met in a series of 1-2 week Joint Application Design (JAD) sessions to determine data reporting needs. When system needs were ascertained, an RFP was issued and after a nationwide search, the software was selected. This "Computer-software off-the-shelf" COTS package met a high proportion of the data needs ascertained by the PHD. A project team contracted with PHD staff to adapt and change the software as needed. All major client-serving programs have been involved with months of staff time devoted to data elements, definitions, rules of business and mapping. During these critical development stages, staff across programs have developed a more integrated view of the PHD client and how to better meet client needs in a "one stop shopping" model.

The data from the former system (PHTurbo) that collected unduplicated counts and numbers of services delivered by programs was then converted to the new system. Computer systems at the state and local level had to be upgraded. The statewide network lines now run directly to the State office, making data uploads and downloads more time-efficient. A help desk was established in conjunction with the WIC program help desk. District level technical staff and trainers were prepared. A comprehensive training program was instituted to prepare staff with statewide rollout beginning in July 1999 and completed in December 1999. FHB program staff making significant contributions in time and effort to INPHORM include Family Planning, Families FIRST Case Management, Maternal Health, Child Health and Children's Medical Services. Susan Nalder, MCH Epidemiology and Lynn Mundt of Family Planning serve on the 10 member INPHORM Steering Committee that meets monthly to review products and approve delivery.

Selected client services programs, such as CMS program, the WIC program and immunizations, need to be integrated into INPHORM. All are scheduled for integration in FY2001-2002 pending availability of funding. The request to the state legislature of $2.1 million for FY2001 was funded at $900,000. Thus the INPHORM team will prioritize tasks and steps towards full integration while continuing to seek funding.

New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS): In July 1997, NM PRAMS and CDC PRAMS and began a 6-month sample. Major funding support is from Title V MCH (2 FTE and operating costs) and a CDC Cooperative Agreement (1.5 FTE and operating costs). From July 1997 – December 1999, the New Mexico PRAMS oversampled Native Americans who comprised ~14% of births. A community contact protocol was instituted with the Navajo Nation to improve response rates. In January 2000, the state PRAMS sample changed and began to oversample by birthweight groups, LBW and Normal or High birthweight. During 1997-1998, the New Mexico response rate was ~55-65%. In 1999, the response rate was >70%.

New Mexico Maternal Mortality Review (MMR): In June 1999, Melissa Schiff, MD, the MMR chair left the state and the MMR team leadership was assumed by Peggy Wollack, MD and Ellen Craig, CNM. The committee continues to be active. New Mexico MMR presentations were made at state gatherings, the 1999 MICHEP Conference in Atlanta and the 2000 ACNM Conference in Anchorage. The Title V MCH Block Grant supports this team with its 1.5 FTE for MCH mortality review (David Broudy Ph.D., epidemiologist and Anna Hopwood, program assistant)

New Mexico Child Fatality Review (CFR): The state team has six special panels: Sudden Infant Death Syndrome (SIDS), Child Abuse and Neglect; Homicide; Suicide; Transportation Related and Broad Spectrum (all other fatal injuries, not motor vehicle). A local team was formed in Las Cruces of Dona Ana County with support from the state team. This local team focuses on Transportation Related fatalities. The first annual report, based on 1997-98 data, was released in June 2000. The Title V MCH Block Grant supports this team with its 1.5 FTE for MCH mortality review (David Broudy, Ph.D., epidemiologist and Anna Hopwood, program assistant).

CSHCN Youth in Transition: The DOH Chief Medical Officer and the Medical Director of the Carrie Tingley Hospital (the Children's Hospital of New Mexico) are assembling a work group to address gaps in services between Carrie Tingley Children's Hospital, other New Mexico pediatric centers, and the Albuquerque school systems. The work group is also addressing adolescent transitioning. The Traumatic Brain Injury (TBI) population will be the first group to be considered as medical and behavioral needs are most critical within this population. The work group is a cross-departmental think tank/problem solving arena for state agencies; problems are to be addressed, policies examined, and procedures created.

The Adolescent/Youth Development Program focuses on researching and funding prevention strategies that have been evaluated and can be replicated as “Best Practices”. The program staff will spend much of the upcoming year marketing those practices statewide. A “ Best Practice” is having youth partner with adults in the policy and decision making processes of program development, implementation and evaluation. Issues that are highlighted by our youth include suicide, abstinence, substance abuse, teen pregnancy and interpersonal violence. One of our most effective program strategies has been the on going work of our Youth Development Advisory Council participating at a decision making level in State office. We are able to model at all levels a true intergenerational partnership with youth.

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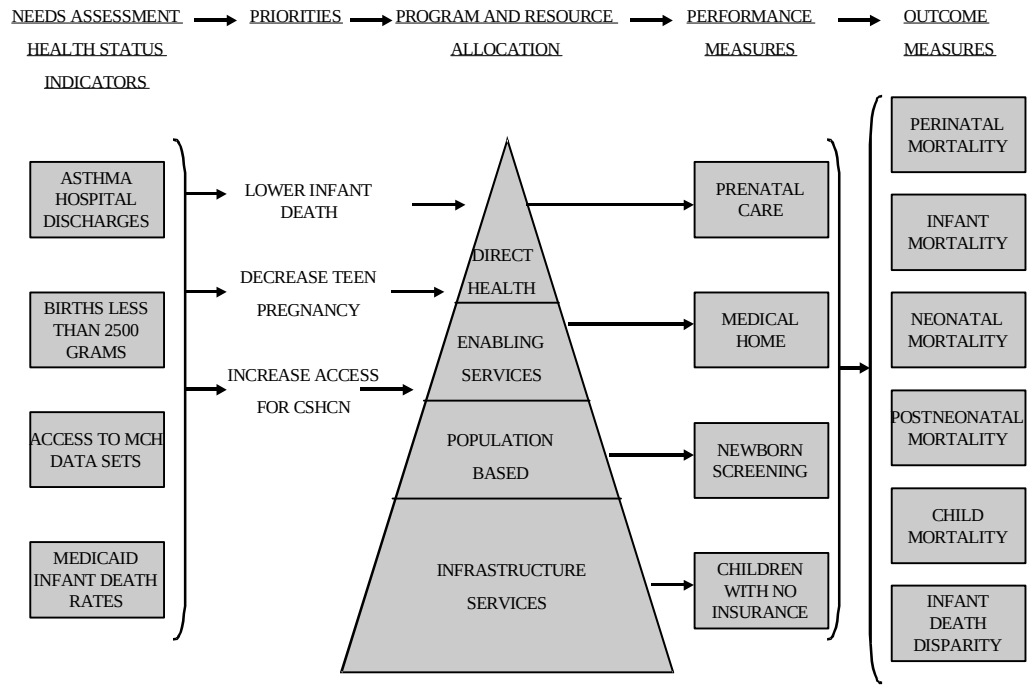
Figure 3

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.2 Health Status Indicators

3.2.1 Priority Needs

The needs statement of FY 99 was reviewed and found to be consistent with policy, the evidence gathered through the needs assessment process and the direction of programs at the community level.

1. Reduce barriers to accessing community-based health and health related services for women, children and youth, and reduce disparities in access to and use of health services by providing client-centered care. E/I

2. Reduce fatal and non-fatal family violence. PB

3. Reduce the incidence of substance abuse and mental health disorders in youth under age 21.PB

4. Expand primary prevention home visiting services to teen parents and first-time parents statewide. E

5. Increase the proportion of women receiving adequate prenatal care. E/I/PB/D

6. Establish an infrastructure to support and monitor transition services for adolescents with special health care needs. I

7. Reduce medical services funding gaps for children in NM, i.e. children who are non-Medicaid eligible, children with orthopedic/rehabilitative needs, and children in need of catastrophic medical funding such as organ transplants. I/E

8. Reduce the proportion of pregnancies that are unintended in women that are 13-44 years old. I/E/D

9. Develop capacity for MCH program evaluation and population assessment to attain timely monitoring of program performance, effectiveness of interventions, status and trend in population measures, and identification of gaps and disparities in health. I

10. Prevent birth defects, poor fetal outcomes and MCH morbidity by reducing violence, alcohol, substance and tobacco use, and promoting health behaviors (folic acid, health diet) among child bearing and child rearing New Mexicans. E/I/PB

11. Develop policies and programs that assure the oral health needs of the MCH population are met, including CSHCN. I/PB/D

12. Establish infrastructure in NM, to support the development of a system to respond to genetic breakthroughs and their implications.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

3.3.2 Other Requirements

The summary budgets are an aggregation of all of the Organization Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Organization Codes are program specific: e.g., Maternal Health, Title V Family Planning, Child Health, Adolescent Health, Children's Medical Services, etc. Each Organization Code is allocated funding showing the federal/state distribution. The state match amount is considerably greater than the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal share of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant for FFY 1999. Any Title V dollars above the amount of last year's appropriation are unobligated funds from the previous year. The unobligated balance (carryover) is due to targeted hits to the Public Health Division's general fund in the areas of staff/positions, contractual funds, and travel. It is the intent of the Title V Director to spend down at least $400,000 of the carryover next year to increase home visiting, repair the damage to the Healthier Kids Fund Program, to explore increasing dental services to pregnant women, and/or to enhance our automated data system (INPHORM). Budget expansions have been submitted for home visiting and Healthier Kids Fund.

The Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured.

The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems development, strategic planning and evaluation, and advocacy.

The budget meets the target percentages for Preventive and Primary Care for Children (35%), Children with Special Health Care Needs (51%), and Administration (is totally paid out of general fund).

The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail.

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3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 4
PERFORMANCE MEASURES SUMMARY SHEET)

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickcle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	**C**	P	RF
SP 19: Increase number of counties adopting the conceptual framework of Healthy Youth, Healthy Communities through an Assets Resiliency model approach, when working with youth				X	X		
SP 20: Proportion of first newborns and mothers receiving support services/parenting through community home visiting support programs		X				X	
SP 21: Reduce unintended pregnancy in New Mexico			X			X	
SP 22:Reduce violence against women, including child sexual abuse, and the no. of children witnessing violence				X			X
SP 23: Implement a NM Pregnancy Risk Assessment and Monitoring System project (PRAMS)				X	X		
SP 24: The state Title V program has a coordinated program of maternal, fetal, infant and child death review.				X	X		
SP 25: The state has a program for Birth Defects Prevention and Surveillance				X	X		
Total Fed Total State	2 0	1 1	7 1	8 5	1 11	2 0	11 2

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

Specific targets include:

- Pregnant women, mothers and infants (including preconceptional women): State measures 20,21,22, 24, 25
- Children: State measures 19, 20, 21, 22, and 24.
- Children with special health care needs: State measure 25 is a primary prevention measure for birth defects. Data can be used to assess health needs for this population.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

3.4.2.2 Discussion of State Performance Measures

3.3.2.4 Review of State Performance Measures

Additional state performance measures that will be more fully developed during FY2000 include the state oral health program's newly developing public health expertise and methods to assess nutritional problems of obesity in children and growth retardation in infants and toddlers. During FY1999, the MCH Epidemiology Program will work with the US Mexico Border Health Office and District III to develop methods for assessing and monitoring MCH in this geographic area. There are two medical epidemiologists in the two offices that will contribute to the effort.

REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

Direct Health Care Services

Children with Special Health Care Needs: There are over 200 specialty outreach clinics in the public and private sector of which CMS sponsors 140 clinics. CMS provided services to 6,581 CSHCN in FY1999, including diagnostics (through the clinics and privately on a fee for service basis), medical interventions, medication, equipment, etc.

Strategic Planning to Improve New Mexico Immunization Rates include:

- Develop and support a statewide immunization registry;
- Promote provider reminder systems, including cards;
- Monitor and provide coverage feedback to physicians and providers;
- Offer technical assistance for evaluation of practice barriers, appointment requirements, etc.

Enabling Services

Service Coordination: Children with special health care needs and their families served by the CMS Program continue to receive service coordination (in collaboration with SALUD!), nutrition care management, translation, and family support services. Support services are provided through family advocates and the Parents Reaching Out (PRO) contract which provides parent to parent support, training and information resources for parents of children with special needs. Transportation continues to be paid to families who are financially eligible (200% of poverty) who do not have Medicaid coverage. Many counties have received funds from the County Maternal Child Health Plan Act (CMCHPA) for county van transportation specifically for the women and children to ensure a means to medical appointments; rural counties have especially utilized this service.

CSHCN Transition Programs: Children's Medical Services (CMS) recommendations for future planning to assist youth with special health care needs in New Mexico include developing medical transition programs and a series of workshops for parents and youth. In addition to these programs, CMS might consider active participation in the Statewide Transition Coordinating Council, the Adolescent Transition Group, and community based transition coordination groups. This coordination is integral to the future of transition services in New Mexico. The following are the hallmarks of effective transition planning for individuals:

- formal planning should be a collaborative effort
- transition plans should be person-centered and focused on achieving a positive outcome for the youth and their family
- the youth's interests and goals should direct the planning process
- the should establish a pathway, focusing on the youth's opportunities and capacities, with measurable goals
- a transition plan should be creative and dynamic

- all participants in a transition team should feel responsible for its outcome and should work to eliminate barriers to cooperation and communication
- a transition plan should be culturally and ethnically sensitive, referenced to the community in which the youth lives.

On a systems level, effective transition to adulthood for youth with special health care needs requires that transition planning provide high-quality, comprehensive, coordinated, continuous services that are cost-effective. Achievement of this goal requires interagency cooperation and collaboration: agencies must cross-train, and interagency agreements should clearly articulate roles and responsibilities, information sharing protocols, methods of communication, and points of contact. Transition councils should include business, community, labor, medical, and state and federal agency representatives. Key components of comprehensive transition plans address the following aspects of an individual's life:

- primary and specialty medical care (including nutrition, fitness, and sexuality)
- mental health care (including family counseling and screening for problems related to depression; tobacco, alcohol, and street drug use; and high-risk behaviors)
- vocational goals (including postsecondary educational or training needs, training in job-seeking skills, or their need for workplace accommodations or assistive technology)
- economic considerations (e.g., insurance, income, work-related benefits, financial assistance programs)
- legal considerations (e.g., guardianships, trusts, conservatorships, rights and responsibilities, draft registration, wills)
- living arrangements (including personal assistance or assistive technology needs)
- life skills (e.g., budgeting, cooking, cleaning, transportation, self-care, self-advocacy skills, communication skills, problem-solving skills, information-gathering skills, personal hygiene, social skills, personal safety)
- social life (e.g., friends, family, life partners/children, church, community, recreation/leisure activities)
- cultural considerations
- service coordination and continuity.

The New Mexico Child Health Insurance Program (CHIP) covers services for children between 185% and 235% of the FPL. NewMexiKids or CHIP enrollment figures to date are listed below. Enrollment in March 2000 is six-fold higher than March 1999. Title V and other public health agencies enrolled a significant number of children in Medicaid through MOSAA.

1999:				**1999-2000**	
March 1999	501	July 1999	1,174	Nov 1999	2,168
April 1999	719	Aug 1999	1,335	Dec 1999	2,383
May 1999	878	Sept 1999	1,639	Jan 2000	2,567
June 1999	1,063	Oct 1999	1,909	Feb 2000	2,968
				March 2000	3,305

Families FIRST is the only model of perinatal case management that is reimbursable under the Medicaid fee for service system. There was no requirement established in the first Human Services Department RFP to provide a consistent model of case management. Currently, each MCO has different benefits for perinatal case management. Included is varying requirements for eligibility, prior authorization, standards of care and reimbursement rates. Below is a synopsis of the covered services allowable under our current contracts with the three MCO's.

1. Cimarron:	5 hours of case management per pregnancy 4 hours per year up to age 3 for all eligible children
2. Lovelace:	3.5 hours of case management per high risk pregnancy No case management services for kids will be covered.
3. Presbyterian:	5 hours of case management per pregnancy 4 hours up to the child's first birthday

Families FIRST is working with the Human Services Department to influence changes in the next RFP for the Medicaid MCO's. Standards of care for case management across the three MCO's would ensure that the clients would receive the same care regardless of MCO enrollment, decrease the bias attitude towards one or more of the MCO 's based on their benefit packages or lack there of and impact low birth weight rates, levels of prenatal care and the State's HEDIS measures.

Population-Based Services

Hear Early: In January 1996, the CMS Program in partnership with the Presbyterian Ear Institute, piloted a universal Newborn Hearing Screening Program which came to be known as the Hear Early Program. CMS purchased equipment and one year of supplies for interested birthing hospitals in the state. By Spring 2000, 99% of the hospitals (all but one) were participating and the percent of newborns screened increased to 98% in 1999 up from 55% in 1996. A tracking system database has been developed and tracks the number of infants screened with this program. Infants failing the initial screen are identified and the child/family is referred to the appropriate CMS social worker for follow-up. An advisory committee has been appointed to guide this new program. A manual was developed to assist social workers with follow-up issues and to gain a better understanding of hearing loss and early intervention strategies. Current issues include tightening up the follow-up system and exploring strategies to accommodate home births. In 1999 a report was done to respond to a legislative memorial (see report in Appendix). An MCH grant has been awarded to CMS to provide improved coordination of the Hear Early Program.

Infrastructure Building Services

The Adolescent/Youth Development Program (AYDP) contracts with a youth coordinator who assists in recruitment and training of the Youth Development Advisory Council (YDAC), 16 members. The YDAC has worked with the Department of Health in planning, implementing, participating in, and evaluating youth programs funded on the state and local level. The Council's main goal will continue to be having

youth serving as advocates for public health, promoting the core health functions which are assessment, quality assurance, policy development and leadership. Through asset based initiatives, youth are having a voice in designing services and programs.

This effort serves as an opportunity to build community and state systems of services with intergenerational partnerships. The focus this FY00/01 is to increase the number of youth who have been trained with appropriate skills to participate as partners in community policy and decision making on youth health issues and increase the amount of training in local and state agencies on this framework. The work continues to be enhanced based on strong partnerships with the Injury Prevention and EMS Bureau, Assist Program, Bureau of Substance Abuse prevention, and the Office of School Health, AYDP is assisting in the development

AYDP continues to provide training, technical assistance, and funding for planning and measuring assets for students in communities adopting a Healthy Youth/Healthy Communities framework. We have surveyed an additional 13,800 youth in the 1999/2000 school year, bringing our total number of students completing the Search Institute Student Profile of Assets Survey to 47,000 youth. This survey implementation demonstrates the adoption of a Healthy Communities, Healthy Youth Framework and the desire by these communities to increase the number of assets their children have for a healthy and safe life. The number of assets reported by our youth is 18 of 40 that held true over the last three years. The results of the year 2000 school year showed an overall total of 19 assets. Although we cannot compare the years, some of the schools participating this year first took the survey four years ago. All the communities participating in the survey have been engaging in asset building over the last couple of years. Research clearly demonstrates those youth having under 20 assets are 50% to 70% at higher risk for engaging in harmful behaviors. Our intent is to continue marketing this model, supporting the surveying of assets in new communities and redoing the surveys in communities with baseline data in the next three years to measure the potential increase of assets and reduction of risk behaviors.

In AYDP's five-year plan, gaps of knowledge within our 18-24 year old adolescent will be assessed, as there is little or no knowledge of health status aside from homicide, suicide, or pregnancy. This population was intended to be included in last year's needs assessment, the vacancy of the health educator position within the program made it impossible to do so. Transitioning issues will be assessed for this entire population inclusive of college Freshman and Sophomores, homeless, incarcerated and those in drug rehabilitation institutions in this up coming year. The status of high school and middle school dropouts and what is the overall employment status of adolescents will also be explored. .

The Program Manager will continue to chair the Suicide Panel of the Child Fatality Review team and will also provide funding for an interviewer to collect psychological histories on suicide victims. Although there is not a single focus in this program, this area needs continued resources of time and funding as the state rate is extremely high.

New Mexico uses detailed planning grids for each performance measure which measures and indicators that are used to monitor progress on the activities. The Title V role and influence of partners/circumstances in meeting or not meeting targets is summarized below:

Fed 01: Although the CSHCN Program is currently contacting all clients who were approved or disapproved for SSI, few children are actually receiving ongoing services from the program. All children either presently on SSI or denied SSI will be contacted.
Fed 02: Title V CMS program administers financing of specialty and sub-specialty services to CMS eligible clients [CSHCN], who have no other resource to pay for care. The new INPHORM system may be implemented this year and the goal is for more detailed data regarding billing in FY2001; the present system can distinguish CMS and Medicaid billing at this time.
Fed 03: Title V CMS program administers 3CR and can ascertain if children have a primary care provider. It does not, however, show the relationship between the provider, the family, continuity of care, or other issues of quality of the medical home.
Fed 04: The Title V CMS program administers the Newborn Genetic Screening services; tests are done at the Scientific Laboratory Division (SLD) and follow-up for positive testing is then managed by CMS. The new cooperative relationship with Vital Records and the purchase of linkage software increases the potential of accurate data. A video was produced and will be distributed which explains the screening procedure for parents and providers.
Fed 05: The Title V program contributes funds for the Immunization Program. Performance on this measure is a function of the effectiveness of the statewide Immunization Program and Vaccines for Children, located in the Infectious Disease Bureau and of the District and Local Health Offices.
Fed 06: The prevention of [unintended and] teen pregnancy in girls age 15-17 is a measure that relies heavily on understanding and responding to the sociocultural and economic environment as well as social determinants in policy and program. A response necessitates networking and partnerships among local, state, and federal organizations, e.g., between the Family Health Bureau's Title X Family Planning Program, the School Based Health Centers of the Community Health Bureau, the New Mexico Teen Pregnancy Prevention Coalition, various other non- and for-profit grass root and statewide organizations, the Youth Assets program, abstinence programs of Adolescent Health/Youth Development Program administered by NM's Title V MCH, the New Mexico Department of Human Services, and the federal Office of Population Affairs. This list is not inclusive but should indicate clearly that many factors and efforts influence this measure.
Fed 07: The state-funded dental health program, through staff and contracted services, offers dental sealants to 3rd grade students statewide in schools with 50% of its students in free or reduced health programs.
Fed 08: Title V monitors data regarding fatal motor vehicle crashes in children age 1-14 and funds a position for the Childhood Injury Prevention coordinator. Social determinants, motor vehicle safety laws

and enforcement, road conditions in NM and effectiveness of seat belt/child restraint education and enforcement all play a role. Significant statewide resources are directed at this problem, across private and public sectors.

Fed 09: Data sources for infant breastfeeding come from the State WIC and PRAMS databases. Key partners with Title V are the WIC program, serving 50% of new mothers, and the efforts of the NM Breastfeeding Task Force.

Fed 10: The Title V CMS program administers the statewide initiatives in newborn hearing screening. The program responded to a legislative Memorial, working in cooperation with the Governor's Commission for Deaf and Hard of Hearing Individuals, to study the current statewide system and make recommendations to the Governor. Effective partnerships with community hospitals and exploration of agreements for midwives conducting home-delivery account for the rapid progress towards achieving the goals. Receipt of MCH grant for newborn hearing screening will strengthen activities addressed by this performance measure and enhance evaluation information for future reports.

Fed 11: The proportion of CMS clients [CSHCN] with Medicaid or private insurance for primary or specialty care can be reported from the CMS client database. Gaps in dental health insurance are remarkable; so are the limited number of pediatric dentists and orthodontists serving NM and/or willing to see children with Medicaid. Pediatric specialists are scarce, consequently the 140+ outreach clinics sponsored by CMS are critical.

Fed 12: The Title V Agency provided leadership in the development of the State Plan for the Title XXI State Children's Health Insurance Program (SCHIP) and impacted the Medicaid Request for Proposal process.

Fed 13: The proportion of children who might qualify for Medicaid and who actually get a card and use a service is a measure that is and will be influenced by complex phenomena, discussed above in 01, 02, 03, 11 and 12. MCH Title V/Family Health Bureau initiatives that will influence this measure in positive ways are Families FIRST Case Management, presumptive eligibility procedures, and services delivered in local health offices such as WIC, CMS, Family Planning.

Fed 14: The NM CMS program has a long tradition of promoting family involvement in policy, planning and implementation of services. These criteria were rated by the CMS Program Manager, Family Voices, and Parents Reaching Out representative. Recommendations were made for family involvement.

Fed 15: Prevention of youth suicide is complex. The majority of such deaths are by family owned firearms. Title V MCH addresses the issue, either through direct involvement such as the AHYD program and CFR programs or through extensive partnerships in school based health centers, the Not Even One (NEO) firearm death community initiatives in Santa Fe and Albuquerque, the mental health in schools initiatives and the suicide prevention initiatives of the Injury Prevention Programs.

Fed 16-17: Title V monitors this data but there is a need to renew some of the network created by the Improved Pregnancy Outcome project, to assess program performance. New Mexico's inability to fully assess the measure lies in restrictions to data for out of state births to NM residents. Approximately, 15%

of births in Dona Ana county [near the Texas border and the El Paso metro area] are out of state and there is no present system to assess performance.

Fed 18: Prenatal care in the first trimester continues to be a priority of the Title V program effort.

SP 19: The AHYD program administers the youth assets and resilience measurement and community action program. Communities, and specifically school boards, are keen to obtain the asset/risk profile. Performance on youth assets, once the measures are produced, are a product of community commitment. The program offers the first data that shows clearly that youth risk behaviors are associated with factors that families, neighborhoods and communities can influence.

SP 20: The proportion of mothers receive home visiting and other support services was negatively influenced by the HCFA decisions regarding services approved in New Mexico's SCHIP Phase II.

SP 21: To reduce unintended pregnancy to less than 30% is a complex undertaking influenced by, e.g., cultural, social and economic determinants; governmental and organizational policies; knowledge, attitudes, and perceptions about sexual behaviors and pregnancy; concerted vs. fragmented efforts by providers and policy makers; and access to and use of family planning services. The Medicaid Family Planning 1115 Waiver was predicted to impact this measure.

SP 22: To reduce domestic and sexual violence, and the exposure of young children to family violence, is an important measure. Coupled with SP 20, state efforts to ensure that all children 0-3 have an equal chance for optimal brain development is a significant challenge because these problems interfere so profoundly and permanently, and exposure of infants and toddlers is thought to be so pervasive. The prevention of sexual and family violence directed at children of all age groups requires a similar effort. The DOH and its partners are focusing on establishing a reliable measure of the number of children exposed to violence.

SP 23: Successful implementation of NM PRAMS is the responsibility of the MCH Epidemiology Program of the Family Health Bureau, with funding from Title V, Title IV, Medicaid and CDC. PRAMS is built on strong partnerships across several agencies which are now able to access the data. Improved response rates up to 70% and higher are the result of revised methodologies.

SP 24: The MMR and CFR teams, managed by MCH Epidemiology, are the results of volunteer efforts by professionals from a wide range of disciplines. Although a project was submitted to MCH/B to support the effort, illness in the grant writer resulted in rejection for late submission. Strong partnerships and a commitment to the programs are expected to sustain the efforts.

SP 25: The NM BDPASS utilizes strong partnerships with community agencies and a determination to reduce folic acid preventable defects and other preventable defects.

PM 01	**Performance Measure 01:** The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. **Healthy People 2000 Objective:** Objective 17.20 Capacity/Direct Health Service	
Public Health Situation or Problem: Children under the age of 16 years may not be receiving the services they need despite being on Medicaid. **Contributing Factors:** The service delivery system is fragmented and complex; This populations' medical needs are being addressed in a Medicaid Managed Care model.		**Measure and Status:** The percent of State SSI beneficiaries less than 16 years old who are receiving rehabilitative services from the State CSHCN program. **Numerator:** The number of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program. **Denominator:** The number of SSI beneficiaries less than 16 years old in the State.
Significance: Title V legislative requirements mandate the provision of rehabilitative services for blind and disabled individuals under the age of 16 receiving benefits under the SSI Program to the extent medical assistance for such services is not provided by Medicaid. The Title V responsibility for providing and promoting family-centered, community-based care serves as a basis for States to establish a policy whereby all SSI disabled children are eligible to participate in or benefit from the State Title V CSHCN Program.		**Data Source:** The Social Security Administration **Data Issues:** The Social Security Administration can only report on children receiving SSI who are age 18 and under.
Annual Performance Objectives: 7/1/00-6/30/2001	**Activities**	**Indicators to Measure: 6/30/2001**
1. Insure that all children on SSI under the age of 16 years have information on the services provided by the Children's Medical Services Program.	1. Notify families of children < under the age of 21 years who were approved for SSI benefits, of services provided by the CMS Program, and assess their ability to utilize resources available to them through SALUD. 2. Continue working with the SSI Advocates Group to insure that families understand the SSI changes, appeal procedures and assist them to negotiate the system.	1. The number of children < age of 16 years, receiving SSI benefits, who were contacted by the program. 2. The number of children/families denied SSI benefits under the age of 21 years who were contacted by the Program.

PM 02	**Performance Measure 02: The degree to which the State CSHCN Program provides or pays for specialty and subspecialty services including care coordination, not otherwise accessible or affordable to its clients.** **Healthy People 2000 Objective:** 17.20–Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions. Capacity/Direct Health Care

Public Health Situation or Problem: CSHCN need a comprehensive system of care coordination in addition to traditional services paid for including medical, habilitative and rehabilitative services, equipment and assistive technology. and compassionate care. **Contributing Factors:** The state is large, rural, sparsely populated with an inadequate number and an unequal distribution of service providers.	**Measure and Status:** The State provides or pays for specialty and sub specialty services not accessible or affordable for sub populations of CSHCN. Checklist of 9 categories of service: Medical and surgical sub specialty services; OT, PT services; Speech, hearing and language services; respiratory services; durable medical equipment and supplies; home health care; nutrition services; care coordination; and early intervention services.
Significance: The care coordination function is critical to assure that families and their CSHCN have access to needed health care in a comprehensive and timely manner	**Data Source:** Title V Program (CMS) rules regulations and treatment protocols. **Data Issues:** None.

Annual Performance Objective: 7/1/00-6/30/2001	**Activities**	**Indicators to Measure: 6/30/2001**
1. Increase to 100% the number of CHSCN who have access to a list of services, and other information about the program.	1. Assure that all CSHCN have access to a list of services and other information about the program..	1. The number of CSHCN for which the 9 services are provided or coordinated.
2. Increase to 100% the number of CSHCN identified as eligible for Title V Program and are participants in needed areas of service: 1. Medical services 2. OT, PT services 3. Speech, hearing and language services 4. Respiratory services 5. Durable medical equipment and supplies 6. Home health care 7. Nutrition services 8. Care coordination 9. Early intervention services	1. Maintain current areas of reimbursement (items 1-9) on checklist. 2. Increase efforts of nutrition screening and referral for services, as well as nutritionists working in CMS clinics. 3. Continue care coordination which is provided by CMS staff and available to all CSHCN and their families. 4. Strengthen linkages to early intervention services and Part C program.	1.The number of CMS eligibles receiving identified services. 2. The number of CMS nutritionists and the children they serve. 3. The number of CMS eligibles receiving care coordination services. 4. The number of CMS staff focused on Part C activities and the number of children served.

PM 03	**Performance Measure 03: The percent of CSHCN in the State who have a "medical/health home"** **Healthy People 2000 Objective:** 17.20 Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions. Capacity/Enabling

Public Health Situation or Problem: CSHCN need a "medical/health home" in order to have accessible, continuous, comprehensive, family centered, coordinated and compassionate care. **Contributing Factors:** The state is large, rural, sparsely populated with an inadequate number and an unequal distribution of service providers.	**Measure and Status:** % of CSHCN who have a "medical/health home." **Numerator:** The number of CSHCN in State who have a "medical/health home." **Denominator:** The number of CSHCN in State.
Significance: The morbidity and mortality of CSHCN without a medical/health home puts them at higher risk for complications and lower quality of life. Care provided in a pediatric or family practice based setting provides coordination which is not available in a fragmented system of emergency and walk-in care.	**Data Source:** Information recorded in the Children's Chronic Conditions Registry (3CR).

Annual Performance Objective(s): 7/1/00-6/30/2001	**Activities**	**Indicators to Measure:6/30/2001**
1. Increase to 85% the number of CSHCN who have an identified "medical/health home."	1. Determine the number of children with a "medical/health home."	1. The number of CSHCN with an identified "medical/health home."
2. Deliver medical home training to physicians serving CSHCN.	1. Work with MCH Collaborative, the American Academy of Pediatrics and Shriner's Hospital to deliver medical home training to physicians serving CSHCN.	1. Number of trainings delivered by 6/30/01.

PM 04	**Performance Measure 04:** Percent of newborns screened by State sponsored programs for genetic disorders and other disabling conditions. Healthy People: 14.15 Increase to at least 95% the population of newborns screened by State sponsored programs. Risk Factor/Population-Based	
Public Health Situation or Problem: Genetic disorders not detected and treated early in life will result in retardation, institutionalization or death. Contributing Factors: Genetic inheritance, congenital mutation, delayed detection and treatment.		**Measure and Status:** The percent of newborns in the state with at least one screening for each of PKU, Hypothyroidism and galactosemia.
Annual Performance Objectives: 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001:**
1. Decrease the number of unsatisfactory specimens submitted by hospitals with consistent rates above average	1. Provide in service training on specimen collection to hospital nursery and laboratory staff. Maintain/update CE course for nurses. 2. Focus attention on training on targeted problem areas. 3. Evaluate training effectiveness	Number of trainings held. Measure number of unsatisfactory specimens from facilities targeted for training.
2. Enhance awareness of Newborn Genetic Screening Program among health care professionals.	1. Publish semiannual newsletter 2. CE course for nurse made available statewide. 3. Continued education for CMS Social Workers 4. Distribute video	Newsletters published. CE courses utilized Educational trainings to all district CMS staff Newborn metabolic screening video will be distributed.
3. Improve data system for linking births and newborn genetic systems and screening practice profiles system.	1. Collaborate with Vital Records/State Lab Division to establish system. 2. Explore funding for needed data linking system (completed 6/00)	System development will occur in FY 01 and accurate data will be made available.
4. Improve follow-up tracking of confirmed cases to ensure appropriate treatment.	Maintain a registry of confirmed cases and establish a method to ascertain child's health status and ensure appropriate treatment.	Number of confirmed cases of CH, PKU, GAL, and SCD. Number of confirmed cases receiving appropriate care.

PM 05	**Performance Measure 05**: Percent of children who completed immunizations for Measles,Mumps,Rubella, Polio, Diptheria,Pertussis,Tetanus, Hemophilus Influenza, and Hepatitis B by age 2; **Healthy People 2000**: 95% of children completed full immunization schedule by 2nd birthday Risk Factor/Population-based		
Public Health Situation: Only 55% of children aged 2 have completed the basic series of immunizations. **Contributing Factors:** families don't understand risks, fear of reaction, mobility of families, lack of referral linkages among programs. Limited clinic appt hours needed.	**Measures and Status:** 1994 1996 1997 1998 State Target % 68 70 75 State Performance 58 63 64 78 CDC Survey		
Planned Achievements 7/1/00 – 6/30/01	**Activities**	**Indicators to Measure 6/30/2001**	
1. By 6/2002, establish statewide immunization information system (SIIS) so participating providers can determine/report immunization status of children 0-6 with linkage to central database	Executive Committee will implement strategic plan including investigation of partnering with the State Medicaid Agency to request funds from HCFA for database.	1. Plan implemented 2. Funds obtained for database	
2. Enroll providers in the Vaccine for Children (VFC) delivery system.	Continuos recruitment	No. VFC providers enrolled	

PM 06	**Performance Measure 06:** By the year 2005, to reduce [or maintain] pregnancies among girls age 15-17 to no more than 50 per 1,000 adolescents; related Healthy People 2000 Objective: 9-7 Risk Factor/Population-based	
Significance: Intended/unintended pregnancy in teens 17 or younger resulting in welfare dependency, school-drop out, parenting problems and child abuse		**Measures and Status:** Rate per 1000 population age group for fertility (live births+fetal deaths + termination of pregnancy) 1996: 48/1000; 1995: 51/1000; 1994: 53/1000

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Expand and enhance the quality of clinical services through partnerships.	Establish or enhance SBHC services: 3. Develop community networks 4. Expand clinic hours and teen targeted services. 5. Data collection for planning and evaluation. 6. Increase access via screening and referral. 7. Promote staff development. 8. Utilize district QA process.	1. Technical assistance sessions for SBHC. 2. Encounters and outcomes of SBHC. 3. Increase of encounters due to expanded services and teen targeted services. 4. Client satisfaction surveys. 5. Client screened and completed MOSAAs. 6. Staff attendance at workshops. 7. Staff satisfaction surveys.
2. Increase services to hard to reach populations by partnering with community based organizations.	1. Inform teens of available services. 2. Develop community networks. 3. Provide community education. 4. Increase access via screening and referral.	1. No. of PSAs, articles, mass media efforts. 2. No. of encounters/organization, areas addressed and measurable outcomes. 3. No. of presentations and market penetration. 4. No. of MOSAA completed and phone referrals.
3. Increase services to adolescents.	1. Targeted outreach efforts for adolescents. 2. Community education efforts. 3. Expanded services such as evening hours, Saturday clinics, walk-in clinics, etc.	1. Site, type, and effectiveness of outreach. 2. No. and effectiveness of education efforts. 3. No. of teens served via expanded services.
4. Expand comprehensive services such as STD and cancer screens and prevention, education and counseling, and substance abuse screens and referrals.	Local health offices will assess provider capacity.	1. Needs assessment completed. 2. Implementation of plan based on above.
5. Increase services to males emphasizing shared responsibility and STD/HIV prevention.	Increase public awareness of need for male involvement.	Trainings held and effectiveness.

PM 07	**Performance Measure 07:** Percent of 3rd grade children who have received protective sealants on ≥ one permanent molar tooth. Healthy People 2000: 12.8 Increase to > 50% the proportion of children who have received protective sealant on the occlusal (chewing) surface of permanent teeth. Risk Factor/Population-based

Significance: Increases in fluoride availability has decreased caries in smooth surfaces. This protection does not extend to the grooves, pits, and fissures of the chewing surfaces. **Contributing Factors:** Family income, education, lack of access to care, low numbers of pediatric dentists/dentists who treat young children, community water fluoridation.	**Measures and Status:** 2000 Target 50% Estimated % 3rd graders w/sealant 42.2% This population-based measure will be assessed for reasonable target in FY 2000.

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Ensure adequate numbers and distribution of school-based sealant providers.	3. Provide school-based sealant program using DOH, and contract staff. 4. Explore Medicaid in the schools as a funding vehicle for school-based sealants	Number of Schools Number of schools participating
2. Ensure sealant placement in under-served areas using a clinic-based strategy.	1. Include payment for sealants in DOH contracted service providers; Motivate I.H.S./FQHC's/Rural Clinics to provide sealant; 2. Motivate private sector to provide sealants;	Number of sites in under-served areas Number of sealants placed state-wide
3. Ensure use of Fluoride mouthrinse in schools located in communities with sub-optimal levels of Fluoride in the water	4. Identify schools with students at risk and not participating in Fluoride mouthrinse programs; 5. Motivate schools with students at risk and not participating to adopt the mouthrinse program; 6. Monitor mouthrinse program by visiting 20% of the schools with mouth-rinse programs; Report annually on mouthrinse program.	Number of schools; Number of schools participating in mouthrinse program; Number of students served; Caries prevalence in mouthrinse schools; Caries prevalence in non-mouthrinse schools.

SP 08	**Performance Measure: 08** The rate of deaths to children 1-14 caused by motor vehicle crashes per 100,000 children: goal is 3.5 **Healthy People:** target set at 3.5 per 100,000 children age 1-14. Risk Factor/Population Based

Public Health Situation or Problem: NM data shows failure to use seat belts and appropriate toddler restraints; alcohol in adult or teen drivers; SUVs; **Contributing Factors:** Lack of adequate transportation for size of family, lack of child car seats, inappropriate number of passengers in vehicle, lack of concern about alcohol consumption; lack of appropriate seat belt laws; inadequate driver training.	**Measure and Status** 1994 1995 1996 1997 1998 Target 3.5 3.5 3.5 3.5 3.5 State Performance 9.0 10.1 9.6 7.3 7.9 Measure deaths/ 100,000 population

Planned Achievements 7/1/99 – 6/30/2000	Activities	Indicators to Measure 6/30/2001
1. Provide promotion, coordination and oversight of overall childhood injury prevention program, including the SAFE KIDS contract, workshops, media events, and public speaking engagements. Continue to collaborate with the county MCH Councils in the development and production of childhood injury prevention programs.	Use CFR and 10 yr. Trend analysis data and information, in addition to internet sources, to continue producing "best practices" program planning information and media messages. Continue to identify appropriate venues for distribution of data and information, and disseminate reports. Continue to collaborate with the statewide SAFE KIDS coordinator on maintenance of existing SAFE KIDS coalitions and chapters, and development of new ones statewide.	1.Trend analysis information updated and distributed. 2. Maintenance of Statewide SAFE KIDS community coalitions and chapters, w/ updated statewide database. 3. New coordinator of Bernalillo SAFE KIDS Coalition hired and trained.

PM 09	**Performance Measure 9:** The percent of mothers who breastfeed their infants at discharge from hospital Healthy People: 75% of mothers breastfeed in early postpartum; 50% continue to infant age 6 months. Risk Factor/Population-Based

Public Health Situation or Problem: Breastfeeding is critical to optimal growth and development of babies. Too many women either do not initiate breastfeeding, or stop nursing too soon.
Contributing Factors: Several known factors associated with not breastfeeding are single motherhood (43% in NM) and need to return to workplace; lack of workplace policies that support breastfeeding moms; insurance policies do not cover breast pumps

Measure and Status

	1996	1997	1998	1999	2000
Target	71%	72%	73%	74%	75%
Ross Lab Survey	72.5%	-	-	-	-
WIC Mothers	63%	63%	54%	63%	-
NM PRAMS	74%*	75%**			

*July-Dec 1997; **Includes .5 1997 and all of 1998

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
Compile WIC and PRAMS data to better assess situation	1. Train WIC staff to assure accuracy in WIC reporting of initiation and duration 2. Revise WIC information system to generate accurate reports of initiation and duration 3. Analysis of breastfeeding data in PRAMS planned by L. Albers at UNM 4. Establish baseline for duration	Staff at all WIC sites will be trained in accurate reporting of breastfeeding data Current WIC Breastfeeding Report validated Analysis of PRAMS data complete for 1999 Baseline established for duration by analysis of 2000 WIC Breastfeeding Report
Increase initiation and duration of breastfeeding by WIC	1. Evaluate current WIC peer counselor sites for effect on duration 2. Provide mini-grants to WIC sites to support duration 3. Continue media campaign to improve public acceptance of breastfeeding 4. Increase hospitals who provide alternatives to e hospital discharge packs sponsored by formula companies.	Peer counselor sites evaluation completed and information available on barriers to duration Mini-grants implemented and evaluated Increase in statewide and WIC initiation rates Number of hospitals increased from 1 - 5

PM 10	**Performance Measure 10:** Proportion of newborns who receive hearing screening. Healthy People 2000 Objective: 17.16 Reduce the average age at which children with significant hearing impairment are identified. Risk Factor/Population Based	
Significance: The financial, educational, and social costs accompanying late identification of children who are born deaf or hearing impaired are great.		**Measures and Status:** 99% of the births are currently being screened Numerator: The number of newborns receiving hearing screening in the state Denominator: The number of live births in the state
Planned Achievements 7/1/00 – 6/30/01	**Activities**	**Indicators to Measure 6/30/2001**
Increase the number of birthing hospitals who are universally screening to 100%.	Assist the one hospital not universally screening to begin screening with the completion of the new Children's Hospital in the city.	The number of screening sites.
Ensure all referrals receive diagnostic evaluations.	1. Fully implement the tracking system; 2. Prepare reports for hospitals from monthly diskettes received on all screens. 3. Verify the diagnostic evals vs. referrals. 4. Utilize birth file for denominator comparisons.	1. Enter feedback from CMS staff into the tracking system and prepare monthly reports of results. 2. Monthly reports are prepared and distributed to interested parties. 3. Track % of referrals that receive evaluation. 4. Compare % infants screened to no. newborns for reporting period and reconcile with reports of "discharged without a screen.
Decrease false positive rates by decreasing refer rate before discharge. (Target is <5%)	1. Encourage re-screening refers before discharge. 2. Encourage one-two week follow up for re-screens. 3. Implement follow up system from monthly reports to trouble shoot problem hospitals/areas.	1. The No. of re-screens before discharge. 2. The No. of follow-up re-screens and time delay. 3. Research "drop-outs" at rescreening to determine ways to encourage follow-up.
Identify system/process of transition from screening to diagnostics.	1. Distribute manual for CMS staff use in implementing the transition from screening to diagnostic process. 2. Provide training. 3. Develop an EI referral system.	1. No. of manuals distributed to CMS staff 2. No. of training sessions 3. An E.I. referral system is in place.
For all infants referred from screening, identify all those with hearing loss by 3-4 months of age and begin intervention by 6 months of age.	1. Continue refinement of tracking system for hearing loss diagnosis by 3-4 months. 2. Assure all new CMS staff have	1. A tracking system is in place; age of diagnosis; 2. No of resource guides distributed to new CMS social workers.

	resource guide. 3. Assure that all referrals are sent to CMS FIT program staff for assistance with families. 4. FIT Social Workers designated as interim service coordinators for infants with hearing loss.	3. Referrals and cases for CMS FIT service coordinators. 4. Part C system includes CMS FIT workers as designated interim service coordinators.

PM 11	**Performance Measure 11:** Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care **Healthy People 2000 Objective:** Objective 17.20 Capacity/Infrastructure Building

Public Health Situation or Problem: Children lack access to health care because of finances, distance from services, lack of providers, and lack of enabling services.
Contributing Factors: Poverty, pre-existing conditions, lifetime caps on certain services
Significance: CSHCN are disproportionately low-income, and because of this, they are at higher risk for being uninsured. They are also more likely to incur more catastrophic expenses than healthier children. They are more likely to obtain health care if they are insured. This measure is an important indicator of access to care. Families often incur high out-of-pocket expenses for medical and non-medical support.

Measure and Status:

	1997	1998	1999
Target	32	34	36
State Performance	32%	32%	57%

Target for 2001 is to make sure all children on CMS are served irrespective of the payer of care. CMS helps families get on to Medicaid, CHIP or other Insurance according to their financial situation.

Annual Performance Objective: 7/1/00- /30/2001	Activities	Indicators to Measure: 6/30/2001
Calculate the number of and report on CSHCN in the CMS Program with available third party coverage– including insurance and Medicaid.	Calculate the number of CMS enrolled children with insurance and Medicaid..	Number of CSHCN enrolled in CMS with insurance or Medicaid coverage this past FY.

SP 12	**Performance Measure 12:** Percent of Children with Health Insurance Capacity/infrastructure Building

Significance: Having health insurance increases access to preventive health care and immunizations. Barriers to health insurance include cost, knowledge of eligibility guidelines, language, attitude, and changes in welfare and Medicaid policies.
Estimates on insurance coverage for children above 200% poverty are difficult to obtain. The working poor are most at risk for being without health insurance. In 1997, 59.3% of the state's children under age 19 were at or below 200% of poverty.

Measure and Status:

	1995	1996	1997	1998
State target, % w/ins	75	74	80	80
Estimate, %w/health ins	76	83		83

Numerator: Total Children Under Age 19
Denominator: Total Children with Health Insurance

Planned Achievements 7/1/00– 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
Health office staff, providers, and community groups will conduct outreach activities to reach previously unserved and underserved families	DOH entities will provide: 1. Medicaid eligibility guidelines and information; 2. Presumptive eligibility (PE)and Medicaid Onsite Application Assistance (MOSAA) services; 3. Information on the Medicaid Managed Care plans and provider networks; 4. Care coordination to follow up on Medicaid referrals; 5. Advocacy to address barriers to eligibility	Children 186-235% poverty and at 185% and below enrolled in Medicaid PE and MOSAA done by local health office staff and/or Families First providers
increase access to comprehensive preventive care for clients participating in Medicaid Managed Care	Work with state agencies and community-based groups to address barriers to access to comprehensive preventive care, qualified providers, and culturally competent services	Identified barriers removed or reduced in the following areas: Transportation; Reimbursement for nutrition assessment; Lack of knowledge of available family planning services; Inconsistent formulary; Language
Continue efforts to obtain complete data on the insurance status of all New Mexico children	SSDI project will implement strategies to obtain previously unavailable data	Accurate data on insured and uninsured children in New Mexico is available
Maintain maximum Healthier Kids Fund caseload of children with no other mechanism to pay for primary services	Provide primary under HKF and ensure coordinated access to HKF, Medicaid, and other payment mechanisms	# Children served by HKF

SP 13	**Performance Measure 13:** Percent of potentially Medicaid eligible children receiving a service paid by Medicaid Process/infrastructure Building		
Significance: Participation in Medicaid after enrollment must address barriers in transportation, access to providers, culture, language, and family centered		**Measure and Status**: 1995 1996 1997 1998 State target, %Medicaid enrolled 75 75 75 75 %Medicaid enroll/qualifying children: 61 72	
Planned Achievements 7/1/00 – 6/30/2001		**Activities**	**Indicators to Measure 6/30/2001**
Implement Title 21 to involve previously unserved children		Approval by HCFA of SCHIP Phase II services will provide opportunities for outreach and access to services that will promote participation in Medicaid	# children receiving a service paid by Medicaid
Address geographic, ethnic, age related, and other disparities in Medicaid participation		SSDI Project will identify disparities and utilize data to promote effective interventions to address disparities	Data on disparities collected and analyzed; Disparities and effective interventions identified
Families First children up to 1 year old will have completed age-appropriate EPSDT schedule		Families First providers will refer and follow up to assure age-appropriate EPSDT	% Families First children up to 1 year old with completed age-appropriate EPSDT

PM 14	**Performance Measure 14:** The degree to which the State assures family participation in program and policy activities in the State CSHCN program **Healthy People 2000 Objective:** Objective 17.20 Process/Infrastructure Building	
Public Health Situation or Problem: Families of CSHCN lack adequate information about programs, and the system of health care in the State. Health care services are typically not family-centered, and input from families may not be sought to improve the service delivery system. **Contributing Factors:** The service delivery system is fragmented and complex; Medicaid Managed Care is still in its early stages of implementation in New Mexico.		**Measure and Status:** The state assures family participation in program and policy activities in the State SCHCN program. Definition: The attached checklist of 6 characteristics that documents family participation. The score is 0-18. Data Source: The State CSHCN Program Data Issues: Whether the checklist is scored solely by the program or with the input of family members.
Annual Performance Objectives: 7/1/00-6/30/2001	**Activities**	**Indicators to Measure: 6/30/2001**
Increase the participation of family members in the CSHCN program by 15 % as measured by the score.	1. Continue to work with Parents Reaching Out and Family Voices staff to obtain input in this scoring process. 2. Explore additional methods for increasing family participation.	1. Number of working sessions to demonstrate collaboration. 2. Family involvement in the CSHCN program as scored by the characteristics outlined in the attachment.

Attachment-Performance Measure #14
SIX CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS

0 1 2 ***3**** 1. Family members participate on advisory committees or task forces and are offered training, mentoring, and reimbursement, when appropriate.

0 1 ***2*** 3 2. Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

0 1 ***2*** 3 3. Family members are involved in the Children with Special Health Care Needs' elements of the MCH Block Grant Application process.

0 1 ***2*** 3 4. Family members are involved in inservice training of CSHCN staff and providers.

0 1 ***2*** 3 5. Family members are hired as paid staff or consultants to the State CSHCN program (a family member is hired for their expertise as a family member).

0 1 2 ***3*** 6. Family members of diverse cultures are involved in all of the above activities.

Total Score ***14***

*0-Not Met; 1-Partially Met; 2-Mostly Met; 3-Completely Met

Total the numbers in the boxes (possible 0-18) and enter the number on the appropriate Performance Indicator row on Form 11 "Tracking Performance Measure by Service Levels of the Pyramid."

PM 15	**Performance Measure 15:** Percent of very low birth weight live births Risk Factor/Infrastructure Building

Significance: Very low birth weight infants bear an excess burden of developmental delay, and costly medical problems. Very low birth weight is associated with increased family stress.	**Measures and Status:**	**1994**	**1995**	**1996**	**1997**
	Target	1%	1%	1%	1%
	Status	1.11	1.03	1.03	1.01
	N VLBW births	306	277	311	271
	D All Births	27,585	26,914	27,216	26,844

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Hire a Maternal Health Program Manager By 8/99	Request permission to fill vacant position; Recruit qualified person; fill position	1 FTE Maternal Health Nurse 5E by 8/99
2. Analyze data and trend for VLBW	1. Conduct analysis by variables; 2. Discuss data with perinatologists in tertiary centers to identify appropriate target groups for prevention of low birth weight	Completed analysis Documented discussions and target groups identified
3. Analyze current provider practices in the prevention of low birth weight	Maternal Health Program staff will conduct targeted structured interviews with key prenatal care providers	Documented compilation of practices

PM 16	**Performance Measure 16:** The rate of suicide deaths among youths aged 15-19 **Healthy People 2000 Objective:** Related to 6.1 and 7.2a Reduce suicides to no more than 8.2 per 100,000 youths aged 15-19. Risk Factor/Infrastructure Building	
Significance: Suicide is the 8th leading cause of death in the US. Among youths aged 15-19 it is the second leading cause of death and has been increasing steadily since the 1950's.		**Measure and Status:** The rate of suicide deaths to youths aged 15-19. The 1997 rate was 12.7 for youths aged 15-19.
Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Develop a suicide prevention network in each health district.	1. Include as part of overall youth development strategy information on suicide issues to communities and schools. 2. Youth Development Advisory Council (YDAC) will present, facilitate, and train other youth and adults at statewide functions on the impact of suicide. 3. Develop and participate in a State Youth Suicide Coordinating Committee. 4. Staff and youth will participate in the development of a youth suicide prevention tool kit for communities.	1. Include suicide prevention recommendations 2. Communities and schools who have received training. 3. Youth presenting and participation in functions. 4. Establishment of committee, documentation of membership, accomplishment of committees. 5. Establishment of tool kits, # distributed in communities, evaluation on tool kit use
2. Chair a Suicide Panel on the Child Fatality Review Team	1. Select and convene a monthly panel to do case review of Suicide deaths of the 10-24 year old population in 1998 and 1999. 2. Contract with an interviewer to collect and document data.	No. of panel members and their affiliations No. of cases reviewed. Final report of findings to support
3. Develop a mental health referral/service system in each school based health center.	1. Work with Mental Health in the Schools Initiative to set up a clear referral pattern and mental health infrastructure for each of the four pilot sites. 2. Include this group in plans as statewide suicide prevention efforts unfold.	Legislation passed based on recommendations of workgroup. District mental health advocates trained in suicide prevention efforts.

PM 17	**Performance Measure 17:** Percent of VLBW babies born in tertiary care centers (TCC) Risk Factor/Infrastructure Building

Significance: Tertiary care centers offer medical teams with a variety of medical specialists and skilled nursing care.
With only two in the state, families are often far from home in tertiary care center, and need complex systems of support.

Measures and Status:	**1994**	**1995**	**1996**	**1997**
Target		(To be set in FY01)		
Status	66.7	70.76	75.2	66.4
N Del at TCC	204	196	234	180
D VLBW births	306	277	311	271

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Hire a Maternal Health Program Manager By 8/99	Request permission to fill vacant position; Recruit qualified person; fill position	1 FTE Maternal Health Nurse 5E by 8/99
2. Analyze current situation and trends regarding delivery at TCC	Discuss with representatives at TCC current practices in identification, referral, and transport	Completed report and distribution to identified stakeholders
3. Recommend strategies for optimal utilization of TCC for best possible outcomes for VLBW babies	Discussion with representatives of TCC and local providers for current practices in referral, identification and transport	Strategies identified and implemented

PM 18	**Performance Measure 18:** Percent of infants born to pregnant women receiving prenatal care in the first trimester Healthy People 2000 Objective: 14.11 Increase to at least 90% the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. Risk Factor/Infrastructure Building

Significance: 63.6% of women enter prenatal care during the 1st trimester

Contributing Factors: lack of knowledge regarding the importance of early PNC; 46.9% of births paid by Medicaid, thus to women <185% of poverty; transportation problems in large counties; lack of providers in rural areas; denial or unwanted pregnancies; younger mothers

	1992	1993	1994	1995	1996	1997
High **LPNC**	46.5	48.6	50.9	52.6	52.7	Not
Medium	35.4	35.8	34.5	30.5	30.6	Avail-
Low/No	14.3	12.6	10.9	11.7	11.8	able
1st Trimester	58.4	62.3	64.9	66.9	67.1	66.8

Planned Achievements 7/1/00– 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Increase 1st Trimester Prenatal care levels to 70%.	1. Develop statewide media campaign to address barriers to early PNC 2. Provide Presumptive eligibility and MOSAA for Medicaid eligible pregnant to decrease waiting time for 1st PNC appointment. 3. Work with Income Support Division to provide direct referrals to FF at the time of Medicaid enrollment 4. Work with the MCO's to develop early identification/referral of their members. 5. Train all FF providers in smoking cessation	1. Campaign developed by 6/30/01 2. # FF women receiving PE and MOSAA services. 3. Process developed by 6/30/01 4. Process developed by 6/30/01 5. # of providers trained in smoking cessation
2. Ensure uniformity of statewide Families FIRST services	1. Approve/Credential new providers 2. Train new providers to FF model 3. Require attendance at FF meetings 4. Perform yearly quality assurance reviews on all providers 5. Revise FF manual to reflect managed care processes	1. # new sites approved/credentialed to provide FF services 2. # of new case manager trainings provided 3. #of providers attending the required meetings 4. # of yearly audits done 5. Revised manual completed by 6/30/01
3. Monitor quality improvement for pregnant women and infants who receive Families FIRST case management services.	1. Monitor # of clients served 2. Install toll free number to improve customer access 3. Develop survey for provider network on the performance of the state infrastructure	1. # of pregnant women and children served 2. Phone line installed 7/31/00 3. Survey developed by 12/00 4. Criteria done by 12/00

	4. Revise evaluation criteria to include MCO standards	
4. Ensure financial access to prenatal care by use of the High Risk Prenatal Care fund	1. Collect and analyze data re use of fund. 2. Refine eligibility categories to best prevent poor pregnancy outcomes.	1. Data reported 2. Eligibility categories updated as needed.
5. Support statewide prenatal care contracts to meet identified gaps in care.	Regular contact with prenatal care providers through site visits/phone conversations.	Site visits recorded, TA given as needed
6. Ensure that public health clinics offering prenatal care receive essential technical assistance and support.	1. Revise prenatal protocols as needed. 2. Visit and/or regularly contact by telephone PH clinics. 3. Provide technical assistance on new or old procedures as needed. 4. Encourage continuing education on prenatal issues by clinic personnel.	1. Prenatal protocols revised and updated ≥ annually 2 ≥ 50% of PH clinics offering prenatal care visited 3. TA provided as needed
7. Promote training, recruitment, and placement of mid-level providers in prenatal care settings (CNM, LM, CNP, nutritionists, social workers, etc)	1. Increase no. of CNMs practicing in NM, and their geographic spread. 2. Encourage independent hospital privileges for CNMs. 3. Increase no. of LMS practicing in New Mexico.	1. # of CNM practices in NM. # of cities and towns with CNM practices present 2. # of hospitals granting independent privileges to CNM's 3. # of LM's practicing in NM

SP 19	**Performance Measure 19:** To increase the number of counties adopting the conceptual framework of Health Youth/Healthy Communities through an Assets/Resiliency model approach when working with youth. Healthy People 2000 Objective: Reduce the number of teen pregnancies among females ages 15-17 to no more than 50/1000 female age 15-17; Reduce the number of youth suicide 15-19 years old.

Public Health Situation or Problem: Research indicates youth report a lack of building blocks or developmental assets necessary to grow up healthy, competent, caring. **Contributing Factors**: Federal, State, Local governments, communities, schools, families commonly address issues by naming problems (e.g. violence, pregnancy, suicide) and try to reduce incidents, rather than building assets/ resiliency or protective factors that nurtures the core experiences needed to be healthy.	**Measure and Status**1994-2000, 56% (18 of 32 counties) have adopted the Assets model. This is an increase of three counties from last year. By the year 2002, increase the number of counties adopting the assets model by or 2 counties to increase to 62% the total number of counties adopting the assets model. FY 2000: 47,000 students completed the survey Search Institute Profiles of Student Life Attitudes and Behaviors which reports individual assets of each student This is an increase of 13,800 students from the previous years.. By the year 2002, increase the number of students completing the survey by 20% or 9400 students
Significance: Youth reporting lack of assets have a higher correlation with risk behaviors (violence, teen pregnancy, substance abuse, suicide, school failure and anti - social behavior) than do youth reporting many assets.	**Data Source**: Data Source: Number of counties requesting technical assistance and training in the Assets/Resiliency Model. Number of Student Profile Surveys completed through the funding of the Adolescent/Youth Development Program, Family Health Bureau, Vital Statistics Bureau. **Data Issues:** Not all counties/schools will chose to surrey their students, some sites will elect to use different measurement tools; sites engaging in this initiative without our assistance have no obligation to report their findings to the state

Planned Achievements 7/1/00– 6/30/2001	Activities	Indicators to Measure 6/30/2001
1. Enhance the operations of the Youth Development Program and Advisory Council to assist the Family Health Bureau, Public Health Division, in the planning, implementation, and evaluation of this initiative.	1. Contract with youth as partners, a minimum of two days a week, in the Adolescent/Youth Development Unit to strategize, design, and evaluate youth programs. 2. Recruit through contractors and youth groups, 16 youth, 12-24, to participate on the Y DAC. 3. Hold 3 quarterly meetings to train youth and share information. 4. Expand YDAC youth outreach to include a minimum of six presentations in local communities 4 presentations to professional groups that work with or on	1. three training meetings with agendas to increase skills and knowledge in addressing health concerns of adolescents 2. # of presentations and training to local communities. 3. # of meetings attended by YDAC as partners around issues of tobacco, substance abuse, suicide, violence prevention, teen pregnancy and abstinence only programs. 4. # of partnerships established with other state agencies to enhance programs for youth.

	behalf of youth.. 5. YDAC partner on issues such as Tobacco, Teen Suicide, violence prevention and Abstinence Only and Teen Pregnancy Prevention programs and Substance Abuse with other bureaus and divisions. 6. Establish partnerships with other state agencies working with youth to enhance programs.	
2. Three new counties/ communities will adopt the Healthy Youth/ Communities through the Assets building Initiative.	1. Provide 4 Health District training on the Asset/ Resiliency Model of Youth Development inclusive of Best Practices in youth prevention programs. 2. Provide 4 County Maternal Child Health Council training on the Assets/ Resiliency Model. 3. Develop a system to distribute A/R materials within each Health District. 4. Provide technical assistance and resources to develop a marketing campaign on A/R Model in counties 5. Provide technical assistance and resources to administer the Search Institute Profile Survey 6. Hire a Health Educator to train in communities and oversee the YDAC.	1. # of trainings to state and community agencies 2. # of participants attending the training 3. # of communities collecting baseline data on youth assets. 4. # of students completing the Search Profiles of Student Life, Attitudes and Behavior
3. Identifying assets that are related to reducing the risk of violence in youth.	1. Follow statewide plan designed from Youth Suicide Prevention Conference. 2. Collaborate with Not Even One and Injury Prevention Programs to raise awareness of relationship between assets and violence. 3. Participate with Child Fatality Review Panel by reviewing case files and providing resources for psychosocial histories of victims. 4. Work with Office of School Health Initiatives 5. Participate on the Statewide Single	1. Participation in the implementation of the statewide plan 2. # of meetings with participation leading to the implementation of asset inclusion 3. Identify # of assets missing in youth completing suicide. 4. Amount of time participating with School Health Initiatives

	Survey Committee to assure protective factors are linked with risk behaviors.	
4. Develop a community assessment tool identifying and measuring the number of asset building activities the communities have put into place.	1. Meet with State Epidemiologists and community representatives, inclusive of youth and adults, in each of the four Public Health Districts to determine appropriate questions and survey methodology to gather information. 2. Select appropriate people to implement the assessment. 3. Select the appropriate sampling strategy. 4. Analyze data	1. # of participants, youth and adults in the planning process 2. # of diverse communities participating completed community assessment tool 3. Increase # of assets identified by youth in communities implementing model three or more years. 4. # of assets increased by communities

SP 20	**Performance Measure SP20**: Proportion of newborns and mothers receiving support services and parenting education through community home visiting programs. Healthy People 2000 7.4: Reverse incidence of maltreatment of children less than 18 (includes abuse and neglect). Enabling/Population Based	
Public Health Situation or Problem: increasing challenges of parenting and providing stable families. **Contributing factors:** Changes in family structure such as increasing numbers of teen and single parents, young parents not prepared to parent their children, high divorce rate, children spending less time with their parents, more children living in foster care, high exposure to violence through the media, high number of children living in poverty, and new scientific research on stimulating brain development in infants.		**Measures and Status**: % new mothers rec' home visiting during pregnancy 1999 7.6 % new mothers rec'd home visiting postnatally 1999 12.5 Number of Families FIRST infants receiving home visits
Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Participate in the establishment of a statewide infrastructure in collaboration with other agencies (public and private) that will support the development of community home visiting/ parenting education programs.	1. Provide TA/ training in order to build training capacity in communities with emphasis on Parent-Child Interaction, early brain development and impact of witnessing violence on development of infants and toddlers; 2. Provide education of and TA relating to critical elements of successful Home Visiting programs 3. Assess existing resources for training and quality assurance and identify strategies to strengthen statewide system for family support	1. Individuals able to conduct trainings incorporating principles of Parent-Child Interaction, early brain development and impact of children witnessing violence. 2. Home visiting programs utilizing some of the critical elements for effective home visiting Inventory of statewide needs regarding training and quality assurance
2. Community-based activities will incorporated into State Title V Program planning to achieve performance objective	Strategies for increasing access and information regarding current status of home visiting will be shared between County MCH Councils and Title V Program	1. # of counties with home visiting as a funded CMCH priority; 2. # of home visiting programs statewide 3. # of home visiting programs with a focus on serving first time families
3. Increase awareness of importance of nurturing skills in caregiving of infants and toddlers	Provide public education to enhance nurturing skills of parents of infants and toddlers.	Impact of media campaign

SP 21	**Performance Measure 21:** Reduce to no more than 30% the proportion of all pregnancies that are unintended in women 13-44 at risk for unintended pregnancy. Healthy People 2000 5.2

Significance: Unintended pregnancy (mistimed or unwanted) is associated with low birth weight, infant mortality, maternal health risk behaviors, low use of preventative services by mothers and their infants. There is a need to promote planned and healthy pregnancies across all age groups and genders. **Contributing Factors:** inadequate access to family planning services; a need to better inform and educate women and men about preconception health, lack of male involvement in sexual responsibility and family planning, lack of FP and other PCPs who conduct a thorough assessment of preconceptional health.	**Measures and Status:** **1997:** 51% of live births were unintended (for all ages)

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Expand and enhance clinical health services.	1. Develop and maintain existing community networks by partnering with providers, schools, First Choice, PA sites. 2. Increase screening and referral by maintaining MOSAA and referral mechanism to providers. 3. Utilize client surveys, community identified needs, and clinic policy to practice district QA/QI process. 4. Develop creative outreach activities for FP; increase cultural awareness and sensitivity activities. 5. Participate in staff trainings.	# of encounters per community organizations #of clients screened for financial eligibility # MOSAAs and referrals completed. # of client satisfaction surveys # of trainings offered and participants # of QA standards achieved.
2. Increase services to hard to reach populations by partnering with community based organizations.	1. Inform public of available family planning services through collaboration with resources such as STD Mobile van, ISD offices, media, health fairs, and churches. 2. Develop and maintain existing community partnerships. 3. Increase access through information, screening, and referral.	# of encounters per community organizations #of clients screened for financial eligibility # MOSAAs and referrals completed. # of client satisfaction
3. Increase services to adolescents.	1. Targeted outreach efforts 2. Community education efforts. 3. Expanded services such as evening hours, Saturday clinics, walk-in clinics, etc.	Site, type, and effectiveness of outreach. No. and effectiveness of education efforts. No. of teens served via expanded services.

4. To expand comprehensive reproductive health services including STD and cancer screening and prevention, education and counseling, and substance abuse screening and referral	1. Establish or enhance clinical services by expanded hours, days, walk-in services, mobile vans, utilizing educational videos, Job Corp, and collaboration with primary care clinics. 2. Develop new and maintain existing community networks through local physicians, WIC and MCH councils 3. Use assessment techniques to assess local provider capacity. 4. Increase educational materials by literature, media, newspaper articles, etc., with focus on male involvement. 5. Collaborate with local churches to increase dialog about males' role. 6. Support staff development in the area of male involvement.	# of clients receiving ECPs, FP services, * served through telephone, flex hours, mobile van clinic # of clients receiving quick start # of teens served in FP clinic. # of educational/behavioral sessions # of encounters Assessment technique(s) utilized # of flyers, PSA's, newspaper articles, pamphlets 8. Type of training, # trained

SP 22	**Performance Measure 22:** Reduce the number of children exposed to domestic violence pr sexual violence. Healthy People 2000: 7.5 Reduce physical abuse directed at women by male partners to no more than 27/1000 couples. 7.7 Reduce rape and attempted rape of women aged 12 and older to no more than 10/1000. 7.4b Reverse to less than 2.5/1000 children the rising incidence of sexual abuse of children younger than age 18.

Significance: Exposure to violence during childhood increases the risk for adverse health behaviors including substance abuse, teen pregnancy, eating disorders, suicide, aggressive and sexual acting out, truancy and school failure. Many children exposed to violence suffer PTSD and receive little or no mental health services.	**Measures and Status:** Rate of domestic violence, rape, and sexual abuse. **1997:** NM Child Sexual Abuse rate was 1.2/1000, 1997 NM Rape rate was 52.8/100,000 (UCR Data). No accurate measure of DV available but data from 1999 study showed that of 19,822 domestic violence police reports, 3710 were present at the scene and 75% were under aged 12 or under. Of the 13,184 clients seen in shelters, 3313 were children who rec'd shelter services. At present, the data cannot be used to ascertain rate.

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Expand the number of people actively working to end domestic violence and who understand the adverse impact on children who witness violence.	4. Continue to strengthen the Domestic Violence Advisory Group, needed legislation, and a statewide definition of DV. 5. Produce an educational video on adverse impact of violence for use by communities and court system. 6. Coordinate and assess sites in state where children are witnessing DV and develop a collaborative approach in response to incidents.	# of people participating Pilot sites coordinated Video produced.
2. Support community based initiatives	Continue creation of local teams	Existence of DV teams in every major town/city.
3. Expand education in schools on date rape and child sexual abuse awareness.	Continue education on good touch/bad touch/secret touch through Coalition against sexual assault and local Rape Crisis centers. Establish stronger coordinated network of agencies dealing with sexual abuse.	# of individuals trained # of agencies/providers participating in statewide collaborative advisory council.
4. Increase the number of local providers trained in the diagnosis/treatment/and mental health referral for sexually abused children.	Offer trainings on these issues at medical and community meetings.	# of sites # of people trained.

SP 23	**Performance Measure 23**: Implement PRAMS and use data for policy and programs; Healthy People: relates to assessment objectives

Public Health Significance: need for data to better understand multiple issues: access to and use of prenatal care and related health services, maternal and partner risk behaviors, social determinants of health behaviors and selected birth outcomes.	**Measure and Status:** Yes/No: 1996=Y; 1997=Y; 1998=Y; 1999=Y; 2000=Y Target: implement PRAMS by FY1998 State performance: PRAMS now into ongoing operations and data analysis July 1997

Planned Achievements: 7/1/00-6/30/2001	**Activities**	**Indicator to Measure: 6/30/2001**
1. NM PRAMS data collection achieves 70% response rate.	1.Monitor response each batch: overall, within strata 2. Evaluate monthly incentive response and adjust according to findings 3.Assess border county performance and Consider community contact protocol	Evaluation of response problems carried out; new issues identified and evaluated; response levels increase with suitable interventions
2. Produce 1997-1999 NM PRAMS data for use in comprehensive needs assessment and publish surveillance report	1. Target depends on NM Vital Records, timely production and submission of 1999 birth file to CDC PRAMS for weighting 2.Complete NM+CDC procedures for weighting 1999 birth cohort data set; Analysis of data, with specific focus on Federal and State performance measures	Submission of birth file by July 15, 2000 return of weighted file from CDC by October 15, 2000 Analysis of data for all performance and health status measures by March 30, 2001 Data used in Title V prioritization and planning processes
3. Provide special analysis on high priority topics	1.As required; expect continued data 2. Analysis on intended nature of pregnancy, breast feeding, home visiting to fulfill performance measure information needs	Special analysis projects completed; disseminated to Community partners; used for program planning, client and provider education, policy
4. Produce analysis of Navajo PRAMS Data in collaboration with Navajo Nation colleagues	1. Identify partners for Navajo analysis 2. Develop analysis plan 3. Produce Navajo PRAMS report`	1. Identify partners by Oct 2001 2. Convene working groups to do plan by Dec 2000 3. Produce report by April 2001
5. Maintain high level involvement of Steering Committee and funding partners	1.Three steering meetings/year 2. Prompt reporting to funders 3. Recruitment of additional partners to support NM PRAMS	Steering committee meetings held; funding of PRAMS continues at acceptable level

SP 24	**Performance Measure 24:** The state has a coordinated program of maternal, fetal, infant and child death review

Public Health Situation or Problem: Vital Records reports provide mortality data by age, gender, Ecode and diagnosis, geo residence. They do not give insight into risk reduction, prevention or systems improvement factors that may prevent future deaths in the MCH population. Death review methods provide this; NM mortality rates for intentional and unintentional injuries are very high.	**Measures and Status:** **1998** **1999** **2000** **State Target** 3/3 2/3 3/3 **State Performance** 2/3 2/3 **MMR/FIMR/CFR Operational = 3/3**

Planned Achievements: 7/1/00-6/30/2001	**Activities**	**Indicators to Measure by 6/30/2001**
1. MMR and CFR teams, including NEO, are fully supported and produce annual reports	1. MMR: fully functioning, has co-chairs and membership 2. MMR: set up data base, enter all cases 1996-present 3. Reports: MMR: produce report by Dec 2000 CFR: all 6 special panels fully functioning CFR: data base set up; all cases entered CFR: produce report by March, 2001	MMR and CFR: teams fully functioning MMR and CFR: combined report published by Dec 2000 MMR and CFR: data used for comprehensive MCH assessment MMR: data presented at national MICHEP, ACOG, and ACNM meetings Disseminate report and results to those who can effect change.
2. Detailed 10 yr. trend analysis for fetal, infant, child mortality data produced	1. Obtain linked infant birth-death data from vital records ; analyze data; produce report 2. Obtain fetal death files for 1995-99, analyze trends, patterns	Update analysis by cause of death in neonatal-postneonatal period. Expand analysis with SES indicators to be complete Mar 2001.
3. Detailed analysis of data for performance, outcome and assessment/health measures produced	1. Detailed analysis produced re: MV Crash, age 1-14; teen suicide, infant, neonatal, postneonatal, perinatal mortality; child mortality age 1-14; and other data analysis related to the surveillance and assessment.	Data produced for use in community outreach in 4 districts for planning by August 2000;
4. MCH death review staff and support staffing needs met	Funding support continues of Epidemiologist-coordinator and 0.5 FTE support person	Staff continues uninterrupted
5. Continue existing community-based review process. Explore opportunities to extend local review process to other districts.	Las Cruces, with US Mexico border health office and district III epidemiologist, set up team, train and conduct reviews, and produce information for prevention.	Las Cruces community based review team development continues; data and information lead to prevention strategies

SP 25	**Performance Measure 25:** Through Birth Defects Prevention and Surveillance (BDPASS) identify children born with birth defects in the state and reduce the incidence of neural tube defects.
Significance: The financial, educational, and social costs accompanying birth defects, especially neural tube defects (NTDs) are very high.	**Measures and Status:** Actual rates of birth defects including NTDs. Numerator: Number of children identified with NTDs and other selected birth defects. Denominator: Number of live births.

Planned Achievements 7/1/00 – 6/30/2001	**Activities**	**Indicators to Measure 6/30/2001**
1. Complete annual report for 1999 births, compile report for 1995-1999	Complete five-year report for births 1995-1999. Complete epidemiological analysis for established rates.	Number of linked records. Completion of report.
2. Complete occurrence and recurrence prevention activities as identified in grant from CDC through Birth Defects Prevention and Surveillance System.	Complete identified occurrence prevention activities and evaluation. Complete recurrence prevention activities including referrals and educational and genetic counseling for affected families.	Evaluation of occurrence prevention outcomes (including data from surveillance system). Number of families referred for education/counseling and number actually receiving it. Evaluation of recurrence process.
3. Complete surveillance of birth defects including NTDs.	Evaluation of efficiency of system including rapid ascertainment of NTDs.	Comparison of New Mexico rates to other similar systems.

4.2 Other Program Activities

Dona Ana Healthy Start Initiative: The purpose of this initiative is to integrate perinatal systems of health care to help eliminate disparities in the health status experienced by racial and ethnic minorities while continuing to improve the health of all women and children. A uniform data collection method has been developed an implemented throughout the perinatal system (the hospital and two large primary care centers). Operations are being monitored and evaluated by the MCH County Council which represents over 45 organizations. 1537 participants (infants and mothers) have been enrolled to date.

Luna County Healthy Start Initiative: During this first year of the program only the perinatal population was studied. There were several findings:

- 58.1% of the pregnancies were unplanned,
- Only 37.8% of the participants using any form of birth control at the time of conception.
- Two-parent families comprised 60.8% of the sample, with 20.3% being single mother households.
- Of the teen group (ages 14-19), 50% live with their parents or the father's family.
- 37.8% did not begin prenatal care as early as they wanted due to obstacles:
    - ✓ 17.6% stated that they did not know they were pregnant,
    - ✓ 16.2% delayed care because of inability to pay for prenatal care;
    - ✓ 18.9% did not begin prenatal care in the 1st trimester;
    - ✓ 4.1% did not receive care until the 3rd trimester;
    - ✓ Only 28.4% had some type of insurance coverage at the time of pregnancy;
- Once pregnant, 14.9% had no insurance;
- 55.4% were covered by Medicaid;
- 21.6% relied on Border Health funds (nonresident status).
- Only 8.1% had private insurance.

Teen mothers were determined to be the highest risk group: 79.2% did not want to be pregnant at the time of conception; 41.7% were underweight at the time of pregnancy; 25% had smoked at least five packs of cigarettes in their lifetime; 33.3% consumed and average of 1-3 drinks per week at the time of their pregnancy; 29.1% went to the ER at least one time during pregnancy; 23.1% of deliveries to teens was by C-section; and 61.5% stayed in the hospital for two or more days.

This project is submitting a proposal for an implementation grant for community-wide interventions. Through a consortium, care coordination, and a risk prevention and reduction model to engage male partners, they intend to reduce family stressors and modify unhealthy behaviors that endanger the health of childbearing women and their families.

The Toll Free Hotline Effective July 1998, a new toll free line was implemented for access to the MCH and CSHCN programs: 1-877-890-4692.

WIC, related education programs, other health, developmental disability and family planning programs: Title V Programs enjoy a close, collaborative working relationship with the NM WIC program. WIC's agenda for prevention of low birth weight has been coordinated with Title V and has shown excellence in practice by adopting facilitated learning and support groups around topics of smoking cessation, infant care, breast-feeding, meeting maternal and infant nutritional needs. WIC is often the program of first recourse for uninsured pregnant women, who are then referred on to appropriate services including Medicaid eligibility.

Similarly, Title V programs work in unison with the Title X Family Planning program's initiatives in preventing unintended pregnancy, preventing teen pregnancy, male involvement in reproductive health, improving birth outcomes through child spacing and preventing poor birth outcomes through a preconceptional health approach to clinical family planning services. The Male Involvement Coordinator has been pivotal in planning and implementing the Department's VAST initiatives. Key FP staff worked with the Title V programs and Medicaid to plan the objectives and strategies for the Medicaid Family Planning waiver, and carry the leadership role in the DOH for implementation and monitoring. Details are provided in the report and planning grids.

Providers of services to identify pregnant women and infants eligible for Title XIX: The Families FIRST program within the F.B./Title V MCH programs is lead in this initiative.

Family leadership and support programs The Home Visiting Coordinator, Doreen Sansom, provides key resources for technical guidance and training for providers of early childhood services. One of four sites opted to include primary prevention of child abuse and neglect through home visiting. Evaluation reports are not yet available.

4.3 Public Input

The MCH Block Grant Application is distributed to Public Health Division local health offices as a resource for their use in planning efforts for local areas. The performance measures are regularly matched with the Public Health Division's Public Health Outcomes for consistency between the two documents. Additionally, the grant is distributed to the County MCH Councils for their county plan updates. The reports to the legislature and its interim committees are based on the information compiled in the grant proposal. The grant proposal is maintained at each local health office for ready access by the public.

4.4 Technical Assistance

The state desires technical assistance in the form of support for systems development, creating a firearm injury surveillance system, developing and implementing a statewide suicide prevention plan, and a cultural competence assessment for the CSHCN program.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and

analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) - The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors
tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an

officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National “Core” Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

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[4] Inter-Censal Estimates for New Mexico, prepared by Bureau of Business & Economic Research at the University of New Mexico; available on the DOH website
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